





# HARVARD MEDICAL ALUMNI BULLETIN

Sept./Oct. 1974



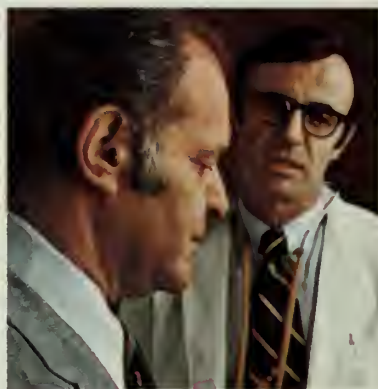
Listening to the Student Perspective

*A. Gillen '74*



# Why add Librium® (chlordiazepoxide HCl) to your cardiovascular regimen?

Excessive anxiety in susceptible patients can set in motion a chain of responses which add to the heart's work and thereby increase the possibility of cardiovascular complications. Furthermore, intense anxiety may interfere with effective medical management since some patients, in an attempt to deny their illness, may resist acceptance of necessary medication, dietary restrictions and other therapeutic directives. When counseling and reassurance alone are inadequate to

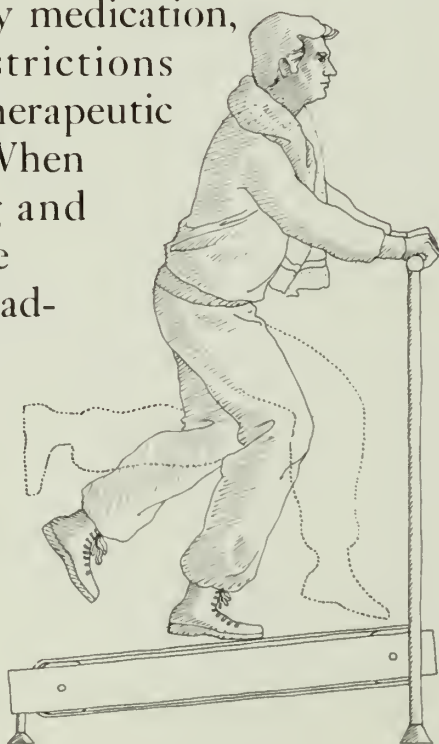


relieve undue anxiety, adjunctive Librium (chlordiazepoxide HCl) may be beneficial.

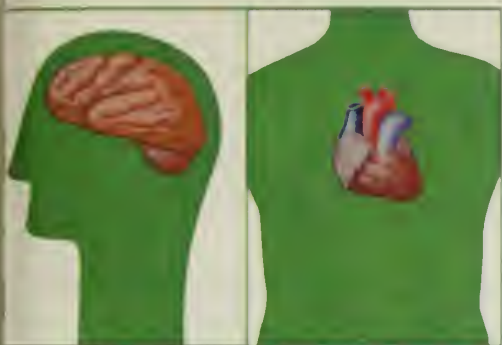
**"Specific" for anxiety reduction...  
wide margin of safety**

Librium is used as an adjunct to primary cardiovascular medications, since it acts directly on the central nervous system, reducing excessive anxiety and emotional tension. In so doing, Librium indirectly affects cardiovascular function.

Librium has a high degree of antianxiety effectiveness with a wide margin of safety. In proper dosage, Librium usually helps calm the overanxious patient without unduly interfering with mental acuity or general performance. In the elderly and debilitated, the initial dosage is 5 mg *b.i.d.* or less to preclude ataxia or oversedation, in-

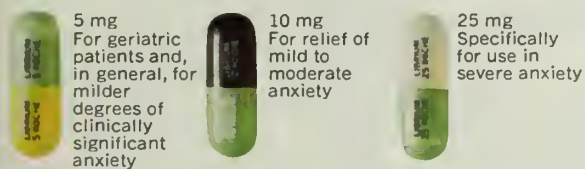






increasing gradually as needed and tolerated.

Librium is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensive agents, vasodilators and anticoagulants. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and Librium. After anxiety has been reduced to tolerable levels, Librium therapy should be discontinued.



5 mg  
For geriatric patients and, in general, for milder degrees of clinically significant anxiety

10 mg  
For relief of mild to moderate anxiety

25 mg  
Specifically for use in severe anxiety

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or over sedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Supplied:** Librium® Capsules containing 5 mg, 10 mg or 25 mg chlorthalidopoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlorthalidopoxide.



Roche Laboratories  
Division of Hoffmann-La Roche Inc  
Nutley New Jersey 07110

For relief of excessive anxiety  
adjunctive

**Librium® 10 mg**  
(chlorthalidopoxide HCl)  
1 or 2 capsules t.i.d./q.i.d.



This is the definitive work — the most comprehensive reference book to date of the diseases of the inner ear.

It is based upon one of the world's largest collections of temporal bone pathology. There are 700 illustrations: photographs and photomicrographs detail the natural history of ear diseases; views of gross and microscopic pathology are supplemented by diagrams and drawings of anatomical points.

A work of inestimable value, it

should be part of the collection of every clinician, surgeon, and researcher in the field.

Dr. Schuknecht is a professor at Harvard Medical School and Chief of Otolaryngology at the Massachusetts Eye and Ear Infirmary. \$35.00

A magnificent set of 250 slides, corresponding to the illustrations in the book, is also available. It is a valuable adjunct to the *Pathology of the Ear*. \$210.00

Commonwealth Fund

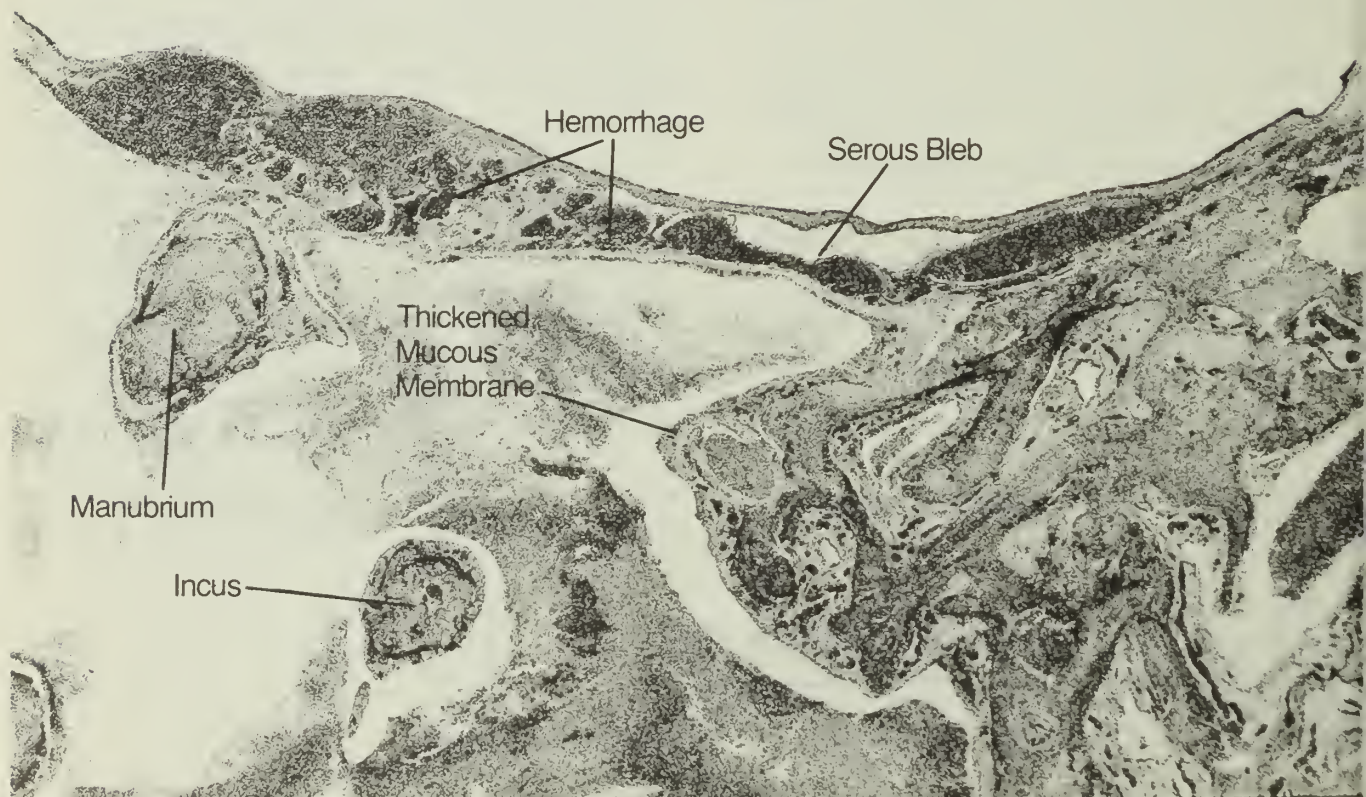
**Harvard  
University  
Press**

Cambridge, Mass. 02138

# Pathology of the Ear

---

*Harold F. Schuknecht, M.D.*





Harvard Medical  
Alumni Bulletin

September-October 1974  
Vol. 49  
No. 1

**SPECIAL ISSUE: Perspectives on the  
Harvard Medical School**

*Editor*  
George S. Richardson '46

*Managing Editor*  
Deborah W. Miller

*Editorial Assistant*  
Gwen Frankfeldt

*Advertising Agents*  
John Reeves Associates, Inc.  
345 Jaeger Avenue  
Maywood, N.J. 07607

Steve Ganak Ad Reps  
Statler Office Building  
Boston, Mass. 02116

*Editorial Board*  
Robert S. Blacklow '59; Daniel H.  
Funkenstein; Tobin N. Gerhart '75; Samuel  
Z. Goldhaber '76; Robert M. Goldwyn '56;  
Franz J. Ingelfinger '36; Jean Mayer, Ph.D.;  
Guillermo C. Sanchez '49; J. Gordon  
Scannell '40; Prentiss B. Taylor, Jr., '77.

*Association Officers*  
J. Englebert Dunphy '33, president; William  
V. McDermott '42, president-elect; Claude  
E. Welch '32, past-president; Oglesby  
Paul '42, vice president; Franz J.  
Ingelfinger '36, secretary; Samuel H.  
Kim '62, treasurer.

*Councilors*  
A. Clifford Barger '43A; E. Langdon  
Burwell '44; Nathan S. Davis '47; Daniel D.  
Federman '53; Milton W. Hamolsky '46;  
Eleanor G. Shore '55; William W.  
Southmayd '68; Jesse E. Thompson '43A;  
Catherine M. Wilfert '62.

*Representative to  
Associated Harvard Alumni*  
Gordon A. Donaldson '35

*Director of Alumni Relations*  
Perry J. Culver '41

*Chairman of the Alumni Fund*  
Carl W. Walter '32

The *Harvard Medical Alumni Bulletin* is  
published bi-monthly at 25 Shattuck St.,  
Boston, Mass. 02115. © by the Harvard  
Medical School Alumni Association. Third  
class postage paid at Burlington, Vermont.

*Credits:* pp. 8, 14, 16, Stanley A. Newfield '76;  
Cartoon p. 10, Ernest Craigie '43A; pp. 15, 28,  
David J. Levenson '76.

- 4 Overview
- Part I — Introduction**
- 8 Getting the First Word  
*by Samuel Z. Goldhaber*
- 9 The Fundamental Questions  
*by Andrew R. Hannas*
- Part II — Curriculum Controversies**
- 12 The Curriculum  
*by Steven Z. Glickel*
- 15 The Clinical Year and Beyond  
*by Martha J. Macdonald*
- 17 The Harvard-MIT Program in  
Health Sciences and Technology  
*by Kenneth R. Bridges*
- 18 A Non-Collective View of the  
Biosocial Curriculum  
*by Paul S. Appelbaum*
- Part III — Diversity**
- 21 Married Students  
*by Mark J. Greenwald*
- 22 Women  
*by Maria C. Savoia*
- 23 Third World Students  
*by Juan Montes*
- 26 Poor Whites  
*by Harold Bursztajn*
- 27 Native Americans  
*by Janice E. Kulik*
- Part IV — Coping**
- 28 Dynamics of Student-Faculty Interaction  
*by David W. Nierenberg*
- 30 The Student-Liaison Committee  
*by Leslie M. Greenberg*
- 31 Portrait of an HMS I  
*by Paul C. Shellito*
- 32 Marriage to a Female Medical Student  
*by Bradley E. Alger*
- 33 A View from the Couch  
*by Samuel Bojar, M.D.*
- 38 Alumni Notes
- 42 Letters
- 44 Death Notices

Cover: A photograph of Dr. Samuel Bojar, psychiatrist to the Medical Area Health Service, counseling an HMSer was rendered in airbrush and ink by Steven Gildea. The technique, photorealism, uses a grid placed over a photograph, which is then transposed, square by square, onto the canvas. Dr. Bojar's contribution to *Perspectives on the Harvard Medical School* can be found on p. 33.

# Overview

## The "Green Book"

The Alumni Survey Committee, as its second project, has begun an exploration of student life and attitudes at the Harvard Medical School. One of the initial findings was a feeling on the part of many students that there is a lack of communication between the faculty, the administration and the student body. It was noted that the last official catalogue of the Harvard Medical School was issued in 1967-1968. This book, as well as previous editions, had a green cover.

Within the last few months, Mr. Herbert Shaw of the Harvard Medical News Office published an informational booklet of the Medical, Dental and Public Health Schools. In addition to some 60 pages of general description, there is an annual supplement to update the listings of administrative officers and faculty and to provide current information about the curriculum and requirements for admission. This booklet has been distributed to the faculty, but, to date, has not been sent to applicants for admission to Harvard Medical School or to the alumni.

Last spring, with the intent to improve the flow of information about life and education at Harvard Medical School, a number of concerned students wrote articles about aspects of particular interest to each contributor. This enterprise has been stimulated and coordinated by Samuel Z. Goldhaber '76. The product, entitled "Perspectives on the Harvard Medical School", has a green cover and has been distributed to the members of the new first year class.

In response to the expressed desire of many alumni to learn more about what Harvard Medical School is like today, pertinent articles from the new "Green Book" are published in this issue of the *Harvard Medical Alumni Bulletin*. In reading these articles, it is important to remember that, with the heterogeneity of today's student body, there is difficulty in reaching consensus on almost any topic. Each article represents an individual point of view and not necessarily a majority opinion. Extreme positions, excessive criticism, as well as confusing, rambling and sometimes downright unintelligible writing are part of present day rhetoric and should not be a cause for overreaction. There are comments which will seem unjustifiably critical of Harvard Medical School to some alumni who remember it more fondly. Before succumbing to irritated indignation, one must recognize that values for today's students have changed in many ways. A medical school can no longer be exclusively involved in the pursuit of knowledge and the stimulation of students to learn. There is now a belief that, in addition, medical schools have an obligation to alleviate social injustice and to improve the health care of neighboring communities. As consumers of education, students take the position that they should be actively involved in directing the course of their education and should have a voice and a vote in making policy.

The need to formalize a system of upper-class advisors for first year students may seem incredible to those who experienced regular contact with members of other classes in Vanderbilt Hall. During the last five or six years,

however, the student body has grown from just over 500 to 680. This increase, together with the fact that there are many more married students, has changed the composition of Vanderbilt Hall residency almost entirely to first year students.

The indication in the "Green Book" that an adversary situation may exist between students and faculty is disturbing. It may appall those alumni who established happy and often enduring friendships with faculty members while at HMS.

During this coming fall, the extent of an adversary state at Harvard Medical School is to be studied in depth by the Alumni Survey Committee. It and the Alumni Council hope to see an early return to better communication and social relations between the faculty and the students.

There are articles in the "Green Book" that are comfortable and pleasant to read. The *Portrait of an HMS I* is timeless. In it, one can detect, already, the seeds of happy nostalgia typical of most alumni. Dr. Samuel Bojar's understanding and sympathetic description of the emotional experiences of a medical student at Harvard is reassuring.

Establishment of a Student Liaison Committee is good news for applicants, medical students and alumni. During the last year, a number of alumni have offered to serve as preceptors or hosts for Harvard Medical students. With a Student Liaison Committee, it will be easier to bring students and alumni together.

Regardless of how alumni react to reading the "Green Book," they owe an understanding vote of thanks to these students who chose to present their perceptions of Harvard Medical School. It may not always be apparent, but they care about Harvard and seek to improve it. There is a strong desire for student power to join with alumni power to make Harvard Medical School more nearly equal to everyone's expectations.

Perry J. Culver '41



## Alumni Office Reviews Offspring Applicants

Perry J. Culver, '41, Director of Alumni Relations, is anxious to follow up and promote the interests of alumni sons, daughters, and grandchildren who apply to HMS. For identification purposes, each alumnus(a) whose offspring is an applicant should write a letter to the Director of Alumni Relations with the applicant's name and undergraduate college so that Dr. Culver can review the application and work with the Admissions Committee.

## HMS Votes Departments of Psychiatry

Six psychiatric hospital departments were voted to be established by the executive committee of the department of psychiatry, Harvard Medical School. The departments and their elected department heads are:

**Elvin V. Semrad, M.D.**, professor of psychiatry — acting head, department of psychiatry at the Massachusetts Mental Health Center, including the Peter Bent Brigham Hospital, psychobiology, and the Laboratory of Community Psychiatry; **Leon Eisenberg, M.D.**, professor of psychiatry — head of the department of psychiatry at the Massachusetts General Hospital, including the Lindemann Center, and chairman of the executive committee of the department; **Shervert H. Frazier, Jr., M.D.**, professor of psychiatry — head of department of psychiatry at McLean Hospital; **John E. Mack, M.D.**, professor of psychiatry — head of the department of psychiatry at the Cambridge Hospital, including Mt. Auburn Hospital; **John C. Nemiah, M.D.**, professor of psychiatry — head of the department of psychiatry at Beth Israel Hospital; and **Julius B. Richmond, M.D.**, professor of child psychiatry and human development — head of the department of psychiatry at the Children's Hospital Medical Center.

## Ten Reach Emeritus Status

Ten members of the faculty of medicine have attained emeritus status. Those honored, and their titles are:

**Bradford Cannon, M.D.**, clinical professor of surgery, emeritus; **David G. Cogan, M.D.**, Henry Willard Williams professor of ophthalmology, emeritus; **A. Stone Freedberg, M.D.**, professor of medicine, emeritus; **Luigi Gorini, M.D.**, professor of microbiology and molecular genetics, emeritus; **Roy O. Greep, M.D.**, professor of anatomy, emeritus; **Arthur T. Hertig, M.D.**, Shattuck professor of pathological anatomy, emeritus; **Herman M. Kalckar, M.D.**, professor of biological chemistry, emeritus; **Harold D. Levine, M.D.**, clinical professor of medicine, emeritus; **William C. Moloney, M.D.**, professor of medicine at the Peter Bent Brigham Hospital, emeritus; and **Thomas B. Quigley, M.D.**, clinical professor of surgery, emeritus.

---

## PROMOTIONS

### Professor

Chilton Crane '38: surgery at Peter Bent Brigham Hospital  
Roman W. DeSanctis '55: medicine at Massachusetts General Hospital  
Walter C. Guralnick: oral surgery at MGH  
Sidney H. Ingbar '47: medicine  
H. Richard Tyler: neurology at PBBH  
Emil R. Unanue: immunopathology

### Associate Professor

Theodore Colton: preventive and social medicine  
J. Alan Hobson '59: psychiatry  
Norman Jaffee: pediatrics at Children's Cancer Research Foundation  
Daniel V. Kimberg: medicine  
Israel Mirsky: mathematical biology in the department of medicine  
W. John Powell, Jr.: medicine at MGH  
J. Stuart Soeldner: medicine at PBBH  
Stuart F. Schlossman: medicine  
Stephen F. Vatner: medicine

### Associate Clinical Professor

C. Grant Champlin Lafarge: pediatrics  
Albert L. Sheffer: medicine

### Assistant Professor

Herbert T. Abelson: pediatrics  
Blanche P. Alter: pediatrics  
Henry G. Altman: psychiatry at Beth Israel Hospital  
Lenore A. Boling: psychiatry at Massachusetts Mental Health Center  
Jan L. Breslow '68: pediatrics  
Richard D. Budson: psychiatry at McLean Hospital  
Joan D. Crain: pediatrics at The Children's Hospital  
Robert B. Dornoff: oral surgery at MGH  
Carl J. D'Orsi: radiology at PBBH  
Horst S. Filtzer '65: surgery at Cambridge Hospital  
Thomas O. Fox: neuropathology  
Michael D. Freed: pediatrics at TCH  
Paul A. Friedman '69: clinical pharmacology  
Richard F. Gibbs: anaesthesia at Boston Hospital for Women  
David J. Greenblatt '70: medicine  
John G. Gunderson '67: psychiatry  
Robert I. Handin: medicine at PBBH  
Stuart T. Hauser: psychiatry at MMHC

Edward P. Hoffer '69: medicine at MGH  
 Philip L. Isenberg '55: psychiatry at MH  
 Dennis L. Kasper: medicine  
 John F. Keane: pediatrics at TCH  
 Edwin H. Kolodny: neurology at MGH  
 Anthony L. Komaroff: medicine at BI  
 Robert S. Lawrence '64: medicine at CH  
 Emanuel Lebenthal: pediatrics at TCH  
 Vilas V. Likhite: medicine  
 Joseph F. Lipinski: psychiatry at MGH  
 Frederick H. Lovejoy, Jr.: pediatrics at TCH  
 Samuel E. Lux IV: pediatrics  
 Eric Martz: pathology  
 Ronald P. McCaffrey: Pediatrics  
 Hubert S. Mickel '62: neurology at TCH  
 Holim Mitry: psychiatry at MMHC  
 Kenneth K. Nakano: neurology at PBBH  
 John E. O'Malley: psychiatry at TCH  
 Robertson Parkman: pediatrics  
 Mark A. Peppercorn '68: medicine at BI  
 Siegfried M. Pueschel: pediatrics at TCH  
 Bernard A. Rosner: preventive and social medicine  
 Robert H. Rubin '66: medicine at MGH  
 Charles D. Scher: pediatrics  
 Gino V. Serge: medicine at MGH  
 Harvey B. Simon '67: medicine at MGH  
 Harold S. Solomon: medicine at PBBH  
 Reynold Spector: medicine  
 Jocelyn Spragg: medicine (immunology)  
 James Steinberg: medicine at PBBH  
 Myron R. Stocking: psychiatry at MH  
 Louis E. Teichholz '66: medicine at PBBH  
 Demetrius G. Traggis: pediatrics at CCRF  
 Nancy E. Waxler: sociology in the department of psychiatry  
 Gordon C. Weir '67: medicine at MGH  
 H. Lee Weith: medicine (biochemistry)  
 Jack Wittenberg: radiology at MGH  
 Bryan T. Woods: neurology at MH

## **Assistant Clinical Professor**

C. Cabell Bailey: medicine  
 Harold L. Chandler: medicine  
 Paul F. Depaola: dental ecology  
 George H. Gifford, Jr. '58: surgery  
 James A. Gregg: medicine  
 Charles J. Hatem '66: medicine  
 Norbert Hirshhorn: medicine  
 Carl S. Hoar, Jr. '45: surgery  
 Alan L. Kaitz '53: medicine  
 Arthur R. Kravitz '54: psychiatry  
 Walter S. Krawczyk: oral biology and pathophysiology  
 Sumner D. Liebman '38: ophthalmology  
 John B. Livingstone '58: psychiatry  
 Doris Menzer-Benaron: psychiatry  
 Donald Ottenstein: psychiatry  
 Abraham Pollen: ophthalmology  
 Louis A. Selverstone '44: medicine  
 Judith E. Singer: psychology in the department of psychiatry  
 Robert H. Talkov: medicine

## **Senior Associate**

Philip A. Drinker: surgery (biomedical engineering)

## **Principle Associate**

Barbara B. Farquhar: computer science  
 James W. Poitras: computer science

## **Principal Research Associate**

Julian N. Kanfer: neuropathology (biochemistry)

# **APPOINTMENTS**

## **Professor**

Edward R. Epp: radiation therapy at MGH

## **Associate Professor**

Philip R. Larsen: medicine at PBBH  
 Sebastiano Santostefano: psychology in the department of psychiatry at MH

## **Assistant Professor**

Harvey I. Cantor: medicine  
 Martin C. Carey: medicine  
 Gregory L. Eastwood: medicine at West Roxbury Veterans Administration Hospital  
 Lowell E. Schnipper: medicine at BI

## **Principal Research Associate**

Franklin A. Sher: pathology

Sandoz Pharmaceuticals introduces

# A FUTURE PHYSICIAN PROGRAM

—providing new opportunities for students to enhance their medical education.

Features of the program include:

- ☐ teaching films available on a loan basis
- ☐ Sandoz Annual Achievement Award
- ☐ guest lecturer programs
- ☐ educational booklets
- ☐ audio-visual aids on obesity, psychiatric emergencies, geriatrics, and other subjects of medical interest
- ☐ other specialized medical services

For complete information about the FUTURE PHYSICIAN PROGRAM contact:



John Staffier

**John Staffier,**

medical school Sandoz representative  
for the New England Area  
100 College Ave, Medford, Mass 02155.  
Telephone: (617) 391-8545

or **Don Gunneson,**

Sandoz Pharmaceuticals, Route 10,  
East Hanover, NJ 07936.  
Telephone: (201) 386-8394.



# Why Perspectives

PERSPECTIVES ON THE HARVARD MEDICAL SCHOOL



Sexing and Summer 1974

The Cover

When alumni return to Harvard Medical School, the prime question on their minds is: "How have things changed?" They sneak into Vanderbilt Hall to see if their rooms are as they remember them. They appoint committees such as the Alumni Survey Committee to examine specific changes in depth. They slap Perry Culver '41, on the back at cocktail parties and remind him to defend their stake in the school, which is too often either undefined completely or confined to assuring their offspring's admission. And there are even some alumni who override their natural shyness, self-consciousness, and embarrassment to approach undergraduates and ask them: "What are things like at Harvard Medical School, these days?"

Every student who answers that question is speaking for him or her self. An individual might be involved with a particular cause and answer the alumni (odds are it's a non-poor white male) from that individual student's perspective.

Although Perspectives on the Harvard Medical School was put together primarily for incoming students, it can serve other worthwhile purposes. Current students can learn many intricacies about HMS that they never dreamed existed. For the editor, now a third-year medical student, this has been an extraordinary learning experience. But alumni can also benefit from having a diverse group of students "tell it like it is." The original version is divided into six parts: introduction, curriculum controversies, diversity, coping, Vanderbilt Hall and the local scene, and conclusion. The last two sections have been omitted from the Bulletin's edition.

George S. Richardson '46, Editor of the Harvard Medical Alumni Bulletin, agreed that alumni could benefit from reprinting most of Perspectives. I want to extend my thanks to him and to the new Managing Editor, Deborah W. Miller.

I have prefaced each article with explanatory remarks about either the author and/or the subject matter. These brief editorial notes appear in italics.

Samuel Z. Goldhaber '76

## Part I - Introduction

### Getting the First Word

by Samuel Z. Goldhaber '76

The Green Book, known formally as *Perspectives on the Harvard Medical School*, is mailed to incoming first-year students during the summer calm, while there is still an opportunity to relax and philosophize before the September storm. It serves many purposes, perhaps, in this order of priority. First, *Perspectives* prods you to ask yourself what going to medical school will really mean, not just in terms of getting a degree but in the sense of how it will affect and help shape your life. Sometimes as students, we do not ask ourselves what medicine is all about until the week we are pressured by finals in biochemistry and physiology. Summer is a good time to sit back and think. Second,

*Perspectives* introduces you to the newest "new curriculum" and in a series of articles, outlines a variety of viewpoints on medical education. No one person could possibly agree with all the viewpoints, simply because they conflict. But familiarizing yourself with different arguments about medical education is a goal worth striving for. This familiarity will lead to a greater understanding of the pros and cons of your curriculum. Third, *Perspectives* recognizes the diversity of incoming students and hopes that with diversified articles, students will gain a better idea of what lies in store for them at Harvard Medical School (HMS) and will become more sensitive to each other.

Fourth, *Perspectives* wants you to recognize right now that HMS is not an ideal world, and that it has problems just like any other institution. We feel that at times, students have such high expectations of this school that it would not be humanly possible to meet them. Through different articles, we explore the positive and negative aspects of student interactions and face squarely the fact that coping at HMS is something that must be worked for. One cannot adjust effortlessly.

You might be curious about the history of the Green Book. It helps fill a void which began in 1967, when the Medical School published its last catalog. Right

now, the News Office has just published a new catalog. But consider the anxiety of applying to a school and being accepted, and yet not having the benefit of an information booklet. During the 1969-1970 academic year, three students in the Class of 1973 decided to try to provide incoming students with at least some information. The Administration provided money for an unofficial publication which was called "An Introduction to Harvard Medical School." It was 36 pages long, pocket-sized, and like a multitude of other Harvard University publications, had a red cover. It was soon known as "the Red Book." In 1972, John Eichhorn '73, one of its three founders, updated and reissued it.

The Red Book reflected the empathy of HMSers for incoming students. But by the time of Class of 1976 received the Red Book, it was outdated. The Red Book seemed anachronistic because it failed to address itself sufficiently to the concerns of married students, women, third world students, and poor whites.

In setting up the format for *Perspectives*, some argued that we should portray HMS as a happy place where there is a lot of togetherness — that we should talk only about the positive and ignore the negative. We disagreed with this approach and believed that those entering graduate school should be dealt with in an intellectually honest way. We encouraged individuals to express opinions and solicited a broad spectrum. We wanted the Green Book to be controversial but as balanced as possible.

Before you read the rest of the Green Book, we want to caution you that *Perspectives*, even with its 17 articles, is incomplete. Topics not discussed include tuition, financial aid, part-time job and research opportunities, joint degree programs with the School of Public Health and the Kennedy School of Government, and clinical rotations at other medical schools both within and outside the United States.

The other warning is that this is a collection of articles written by 17 people. There is no pretense that any individual author is speaking for a particular group he or she is writing about. The articles are not a collection of Harris polls, but a combination of facts with reasonable

people's personal opinions. Reading the Green Book is not a substitute for speaking to a variety of upperclassmen, faculty, and administrators when you arrive at HMS.

Finally, we want to give special thanks to three individuals. Frederick C. Lane, Dean of Students, provided the initial encouragement for this project. Herbert A. Shaw, Director of Medical Information in the University News Office, ushered the Green Book from its untyped form to the finished product. And last, Marvin J. Bittner '76, has devoted an inordinate amount of time to the Green Book. He helped edit the articles written by the editor and provided helpful ideas and encouragement.

Psychiatrist James A. Knight, author of *Medical Student: Doctor in the Making* (New York: Appleton-Century-Crofts, 1973), wrote:

"Students are often told on the day of entering medical school that when the sun goes down, they will be far behind in their work and will never catch up in their lifetime. When the day ends, students are convinced that the prophecy has begun to unfold. The wise ones develop an existential stance and try to live fully each day, for today is all they have for certain. When tomorrow comes, it will bring a new set of demands and will permit the consideration of very little of that which was unwisely put off from yesterday."

## The Fundamental Questions

by Andrew R. Hannas '76

*Some alumni will not understand this article. Andrew R. Hannas '76 (some of you may be acquainted with the dynamic R. R. Hannas '50) takes a philosophical approach to the most basic questions of student existence at medical school. His complex article should be read slowly, as a postprandial activity. Perhaps it can only be appreciated by those who have been asked literally hundreds of times: "Why go to medical school?" Those who never considered the alternatives may also fail to grasp the significance of what the younger Hannas is saying.*

What will it be like at Harvard Medical School? At various times and in various places, you may come across the typically empty descriptions: "Harvard Medical School is such a fathomless, intangible entity that no single stroke or cluster of images can adequately portray its essence." Or: "Students at Harvard Medical School are highly intellectual and individualistic, with such diverse talents and interests that generalizations about the school are impossible." While it is mundanely accurate to say that the HMS experience will be an "individual" one, it is perhaps less obvious that the experience will not be an "intellectual" one. Indeed, despite an overt and probably genuine effort to appeal to one's rationality or intellect, HMS will exert its greatest effect *emotionally*. This is not emotion in the sense of "pride" or of "feeling good" about being a member of an "intellec-

tual community." If anything, it is the opposite.

It is the feeling of *frustration* at being a member of a community whose members are unsure of their goals, refuse to espouse a common goal, and answer the student's questions by urging, "Develop your own interests." It is the feeling of being *antagonized* (or *humiliated*) in the classroom and hospital situation by someone who was antagonized long ago (or not so long ago). It is the feeling of *infuriation* at the way many people behave at times around HMS. It is the feeling of *cynicism* that runs deep in Amphitheatres C and E, especially up in the back rows and over in corners. A healthy cynicism — maybe some see it more as skepticism — will smooth over many otherwise intolerable (intellectually, emotionally, sexually, racially) statements made



with emphasis, sincerity, proper accent, wit, and appropriate diction and syntax at the bottom of those amphitheatres by authorities all of whom are experts in their fields and most of whom are "intellectuals." The cynicism also will touch off that roving, jaundiced eye during the occasional lag in the excitement of the amphitheatre stage. "Isn't this a weird place? Aren't these people really strange? How in the world will I ever become a doctor? Why am I here?" As the months pass, the questions become louder; their content, proportionately monosyllabic.

In short, peace of mind will not be found at HMS. Nor will one find a day-to-day routine, 8-to-5, railroad-track approach to "turning out doctors as fast and as efficiently as possible in order to meet the needs of the people and the health care system." It has been said that doctors are trained, not educated. Well, HMS refuses to train and expects one already to have been educated. Again, the burden is on the individual to define his approach to his HMS experience. In this respect, one will not find someone at HMS saying what a student should or should not do. As in most academic environments, freedom and guidance will often seem mutually exclusive.

Because almost every student formulates an intensely personal expression of the reasons for going into medicine, the individualistic atmosphere encountered at HMS is initially rather refreshing. After the newness wears off, however, those intricate, well rehearsed phrases that could hypnotize relatives and dazzle admission committees begin to gather dust in that special part of the cerebrum that got high grades, high MCAT scores, and good letters of recommendation. Some students will have remarkable recall of these reasons, as if they were on permanent loan from a record library. But usually the neatly-bound package of reasons and sub-reasons for wanting to come to HMS becomes displaced by the more primitive "Why am I here?", necessitating complete reassessment and reformulation of attitudes and aspirations. Although deceptively simplistic, the question in its broadest sense should confront every student virtually every day he or she attends HMS. Otherwise, the student is not being critical enough. Similarly, every student should *answer* this question (satisfactorily or unsatisfactorily), for not to do so will necessitate insulation if not isolation from the medical community. Such an answer will represent the student's rationalization, justification, or "philosophy" behind the steps he or she has taken in medical school or is about to take following medical school. The "answer" should not come so easily and quickly that a student's horizon is narrowed. There is enough time at HMS to sort life out tentatively — and an astounding number of paths to explore along the way — if one consciously works at it. If not, the forces at work behind the scenes in the medical community can drag one along, tossing out bits of cheese, glasses of sherry, boxes of cigars, and bottles of beer (as well as an occasional polished, inspirational lecture), subtly channeling one into attitudes and directions which the student *thinks* are self-chosen but which never really *answer* that question, "Why am I here?" The cheese can be eaten and the beer drunk without falling into the trap, but watch out for the sherry.



So, why *is* one here? The germinal responses seem to express two ideas: "I am here because (I think) I want to become a doctor" or "I am here because (I think) I have no better alternative." To further distill these two responses: "I am here because (I think) I want to be here" or "I am here because (I think) I don't want to be anywhere else." The "(I think)" is in each case the student's safety valve. It will goad, but it will allow

release when the question "Why am I here?" threatens to strangle even the most acceptable stage of answer a student (thinks he or she) has developed. The thoughts that follow are not intended to make answering the question any easier. They are meant to serve primarily as a warning to those who will try *not* to answer the question (or indeed, to try not to ask it). Their own deference will pose the greatest danger they will face at HMS. Secondly, these thoughts are intended to serve as a suggestion to those who will respond initially by saying they are here because of no better alternative. Their negativism will signal the greatest need for their *continual* re-examination and reconsideration of why they are in medical school.

From time to time, appropriate personages will remind students that after four years of basic sciences, clinical rotations, and National Board exams, the M.D. degree is attained. Consequently, one is reminded, it is important if not imperative to keep this goal in sight, to keep things in perspective. The title — *Medicinae Doctor* — represents, one hears, the individual efforts of four years, the collective efforts of hundreds of students and faculty, and the backing of hundreds of thousands of dollars. Implicit in these attitudes, or derived from them, are the notions (1) that four years of individual efforts have been fruitful and deserve recognition; (2) that students and faculty have been united in such efforts; and (3) that the degree, itself priceless, is a virtual blank check for its owner. The voice representing the first attitude is usually the student's; that representing the second, the Dean's; that of the third, an insurance salesman's.

Such attitudes are not without truth, nor are they incompatible with whatever paths a student explores. Where they do obscure or distort the actual reality of the four-year experience and the potential reality of the years ahead is in their consideration of the degree as a goal, something good in itself, even if immediate. The goal of getting into medical school is not to be equated with the practicality of getting through medical school. The intrinsic value of the M.D. degree is the same as the intrinsic value of four years of medical school, but this value is *not* the same as four years of secondary education and a di-



ploma, followed by four years of college and a Bachelor's degree, followed by the Master's, Ph.D., etc. Medical School is not just another in a progression of academic or quasi-professional plateaus in a student's life, to be followed by its own endless procession of appointments, each with its special reward or "goal." If, however, the student chooses (or lets others choose), he or she may consider the degree in this respect, in which case its value does indeed lie in its status as a goal, a plum to be kept in sight and devoured when ripe. And, conveniently, HMS will roll out the carpet for those who pursue this course. Partly for self-glorification but mostly for self-preservation, HMS will attempt to lure ("to recognize academic excellence") students into making sure they heed the voices, that they do in fact keep things in perspective.

Alternatively, the student can attempt to get off this conveniently automated treadmill. The medical school experience should be the substance of such an exit, and the M.D. degree should symbolize it. In this way their intrinsic value derives not from the knowledge they represent but from the *object* of that knowledge: the skill to help people, especially sick people. And, as far as goals are concerned, it is the object of the knowledge of four years, not the symbol of the knowledge, that the students should keep in sight, in perspective, and it is the *form* of the object that will be the career — the "answer" — the student chooses. Again, the question must be asked daily, and the answers explored actively.

Why put so much emphasis on a degree which no student really worries about anyway? The reason is simple: the M.D. degree is the central concept around which pivots the triad of (1) *medical knowledge*; (2) the *object of that knowledge (skills)*; (3) the *form of that object (a career)*. A student's attitudes toward the degree and toward the four years themselves will condition if not determine these very three things, the student's knowledge, skills, and career, both immediately and ultimately. Were these of no consequence to anyone but the student — if, for example, no one except the student cared whether he or she pursued a career in public health, cancer research, neurosurgery, or internal medicine — attitudes during medical school would

not matter quite as much, especially if such attitudes are fundamentally sincere. Once upon a time, the career an HMS student chose was not really important, as long as personal interests were being developed along the way. The *form of the object (a career)* was less important than the *object (skills)* and far less important than the medical knowledge itself.

Unfortunately, this is not the case today. The urgency to make decisions, to develop appropriate careers as well as attitudes, renders the development of attitudes a great responsibility. Such urgency stems neither from the needs of the HMS community nor from those of the nationwide medical community but from the needs of society itself. This, too, sounds passé nowadays, but the needs of people, especially sick people, are such that a student can no longer choose a career on the basis of interest or talent alone. And HMS, and its myriad opportunities, does little to help the student discriminate (either indirectly in terms of curriculum or directly in terms of counseling) with regard to medical knowledge, skills, or career options. HMS would rather have students arrive by a strange and inefficient, if not ineffectual, combination of personal interest, random choice (or non-choice), and positive reinforcement at a career (the *form*) which may or may not be serving the *object* of the knowledge (the skills to help society) in a worthwhile manner. This is not to say that society does not need all types of doctors or to endorse community medicine over research. It is a statement that society's problems should influence strongly a student's particular *field* of basic science research or public health.

Indeed, one cannot make the assumption that there is any fundamental difference in outlook within any of the various spheres of interest at HMS. To single out any as "at fault" would be not only inaccurate but also naive, for one need only pose the following question to see that all of HMS has a stake in shielding its students from too strong an influence from outside forces: if people didn't get sick, doctors would be out of work, right? Wrong! The medical profession, particularly HMS, is self-perpetuating because disease is defined currently by doctors, not by those who are ill. This applies both to research and to clinical medicine. Ex-

tending the notion of self-perpetuation, one can see why HMS would be reluctant to guide students into roles that HMS has not defined. If nothing else, the powers that be at HMS do *not* show suicidal tendencies.

If, then, HMS will not guide students into those roles which are being more and more dictated by society and not by the medical profession, who will? Society *could*, but to the student in the academic environment, where is society? In Vanderbilt Hall's dining room? In the Amphitheatres? In Building A? The individual student is once again the answer, although this time by default. HMS, by giving students so much freedom, by flattering their "individuality," is avoiding cleverly the great responsibility of guiding students into those roles whose existence society defines and demands. With the responsibility for carrying out this task on his or her shoulders, is it any wonder that it is inadequate for a student to rest content saying, "I am here because I have no better alternative"? Is it so strange that a student can no longer choose any field that interests him or her without first considering the impact of this choice upon society's needs? Is it so difficult to understand why attitudes toward the M.D. degree and toward four years of medical school are so crucial?

With active exploration of these kinds of problems, the student can answer "Why am I here?" with a career that is in harmony with personal interests, the medical community, and, most importantly, the needs of society. This exploration can be fun, exciting, and at times even inspirational. Undoubtedly it is in wrestling with these forces that the Harvard Medical School experience becomes for each student more emotional than intellectual.

# Part II - Curriculum Controversies

## The Curriculum

by Steven Z. Glickel '76

*It's almost impossible to keep up with the curriculum changes at Harvard Medical School. Most alumni had the standard two years of basic science, which except for a semester of pathophysiology was taught on a departmental basis — such as biochemistry, physiology, and microbiology. Then in 1968, the new "core curriculum" was ushered in, with one and one-half years of basic science taught inter-departmentally by organ systems — such as cardiovascular, respiratory, and renal. Now in 1974, the curriculum changes once again, to simulate much of the pre-1968 one. The new "new" curriculum has almost two years of basic science, mostly taught on a department basis. Steven Z. Glickel '76, class representative to the Curriculum Committee, explains the details of the newest curriculum.*

I have the dubious distinction of informing your class of a curriculum about which I know something, many faculty know less, and most students know virtually nothing. The sole source of my familiarity with this subject is membership on the HMS Curriculum Committee, which formulated and will begin to implement this new course of study.

Due to its newness, there is considerable confusion and circulating misinformation, some of which I can hopefully dispel and none of which I will intentionally propagate. Bear in mind, however, that my interpretation is fallible and that this is not the definitive statement on your curriculum. If, when you arrive in the fall, you encounter some scheduling problems, going to the Registrar and claiming that "Glickel said so" will get neither of us very far. With this preface of equivocation, I proceed.

The current curriculum which began in 1968 will continue for the classes ahead of you. For many reasons, it is considered deficient; hopefully, recent revisions will eliminate some of those deficiencies for future classes.

Generally, the curriculum can be divided into preclinical and clinical segments with some overlap between the two. The preclinical period, for the great majority of students, will involve the first

three semesters on a full-time basis and, during the fourth semester, will be mixed with clinical work. The clinical period will begin in the fourth semester and continue until graduation. Three half courses (see below) of non-clinical electives will be required of all students during the clinical period.

A modified semester system will be in effect. Semesters will last approximately four months, from September through December and from February through May, with January and June set aside as blocks of time for reading, electives, or vacation. Particular requirements will be dealt with later but I should mention here that a minimum of 132 credits is required for graduation and the amount of vacation time may depend upon how you distribute your credits. The average student will have four weeks spread over winter, spring, and Labor Day vacations, and one additional month per year.

The distinction between longitudinal and block courses is that the former are taught during an entire semester for several hours per day for one to three days a week, and the latter for two or three times as many hours per day, five or usually six days a week. Either way Saturday morning classes are unavoidable. Block courses are customarily

taught as single subjects during multiples of one month periods. A one month block is equivalent in terms of credits to a four month longitudinal course. By way of clarification, all courses are weighted as half, quarter, or eighth courses with four, two or one credit attributed, respectively, to each. A half course is officially defined: (1) for longitudinal courses as "an approved course requiring a minimum of ten hours per week of classroom and out-of-class time over a full semester" and (2) for block courses "... requiring a minimum of 40 hours per week of student time over a period of four weeks." Quarter and eighth are the appropriate fractions thereof.

One of the outstanding features of this curriculum is its flexibility. Depending upon past experience and current preferences, students along with their advisors will design individualized schedules which can follow any one of many yet unspecified permutations. All paths, however divergent, lead to the M.D. More specifically, the courses in the first year will generally be "basic science" in orientation sponsored by basic science departments presumably with input from the clinical faculty. Each student will be required to take seven half-courses in basic science which include areas such as biochemistry, his-



tology, neural science, physiology, anatomy, pathology, immunology and pharmacology. Exactly when each particular course will be offered and how many courses might be offered in one general area are undefined thus far. If, for example, an acceptable course is in fall and spring semesters of the first year, you and your advisor will decide when you take it.

You will also be required to take five half-courses in pathophysiology and one approved quarter-course in social science and one in behavioral science. Pathophysiology courses are organized according to organ systems and will represent the combined efforts of basic scientists and clinicians to correlate morphological and functional with clinical changes in disease. Pathophysiology courses will be taught in fall or spring semesters, thus allowing students to begin pathophysiology in the second semester. Presumably social and behavioral science courses will be available both as longitudinal courses during the four month semester and as one month block courses during January/June periods.

Most students will take four half-course equivalents in each of the first two semesters. The ambitious or well prepared student can take five courses. The less well prepared student can take three courses and make up the deficit at a future time. It should be emphasized that such time will exist; if you are worried about your ability to handle the work load, rest a bit easier because you can go at a slower pace.

Students are eligible for advanced standing based upon previous course work or demonstrable competence in an academic area. Advanced standing can be obtained by applying to the Admissions Committee before you begin class or to the respective department before or after arrival at Harvard. Heretofore, placement examinations have been given during the orientation week and presumably a reasonable facsimile will be retained.

During the fourth semester, February through May of the second year, you will be expected to take two courses from any of the following: basic science, pathophysiology, social and behavioral science, or any appropriate elective if you have already completed the re-

quirements due to advance standing and/or a heavy schedule. That same semester will represent your first prolonged exposure to patients and clinical medicine in the form of "Introduction to Clinical Medicine." You will learn how to approach patients, to perform a complete physical examination, and to formulate a differential diagnosis. ICM (the medical world is noted for the incomprehensible proliferation of abbreviations for absolutely everything) will be taught all day Monday, Wednesday, and Friday. The other longitudinal courses will be on Tuesday, Thursday, and Saturday.

Then follow the core clinical clerkships, elective clinical clerkships, area of concentration, and additional nonclinical requirements.

The core clinical clerkships encompass three continuous months in medicine, two continuous months in surgery, and a single month in three of the following six areas: pediatrics, obstetrics and gynecology, psychiatry, neurology, orthopedic surgery, and dermatology-ophthalmology-otolaryngology (triple threat). Beyond the three required months, the other three core courses may be taken during the elective period. A minimum of ten half-courses is required as electives and *must* include at least three nonclinical electives and at least four clinical electives, the remainder (three half-courses) are free and unrestricted. The nonclinical electives may include advanced courses in basic science, tutorials, seminars, research, or anything else considered suitable by the governing bodies which approve courses. Furthermore, you will be required to choose an "area of concentration" which must include a minimum of six half-courses. Preclinical and core clinical requirements *cannot* be applied toward fulfillment of the area of concentration requirement. However, the additional three months of nonclinical electives *can* be applied. The areas are still being delineated, but the following suggestions have been proposed: neurosciences; behavioral sciences; social sciences; reproductive and developmental sciences; endocrinology, metabolism, and nutrition; musculoskeletal and connective tissue; cardiovascular, respiratory, and renal systems; microbiology and infectious diseases; and oncology. Let me emphasize that these areas may be

changed. In any event, areas not clearly subsumed under the above categories can be worked out between yourself and your advisor and, if approved by the appropriate committee, are perfectly acceptable for graduation credit.

The temporal sequence in which the core clerkships, nonclinical electives, free electives, and area of concentration are completed is entirely up to your discretion, barring such problems as prerequisites. Generally, however, it is considered advisable to take Medicine and Surgery prior to the fourth year in order that they may be included in the evaluation letters sent to internship committees. Otherwise, there is no universally preferred order. One advisor may tell you one thing; another, quite the opposite.

Approximately 25 members of your class have been accepted into the Harvard-MIT Program in Health Sciences and Technology leading to the M.D. degree at Harvard Medical School and combining the facilities and talents of MIT and HMS. In the first three semesters it stresses the physical and technical aspects of medicine in a distinct tract within the larger HMS curriculum. After the first semester the HST curriculum is substantially organ-system oriented, and from the fourth semester onward the HST and HMS curricula are indistinguishable. My principal reason for mentioning HST in this article is that HMS students can elect to take some of the HST courses. It must be borne in mind, however, that probably the greatest virtue of HST is the small size of its classes. Some may be opened to more students than previously, but this is entirely speculative.

All students will be graded on an Excellent-Satisfactory-Unsatisfactory system during the preclinical periods.

At this juncture, I will give you a slightly different perspective on the "new curriculum" than the Administration's literature and speeches at orientation.

To begin on a positive note, let me point out that of the approximately 30 members of the Curriculum Committee, there was only one dissenting vote on the question of approval of the curriculum. Two of the students on the committee voted for approval: one



(yours truly) voted against. The Faculty of Medicine passed it in two sessions without significant modification. The meetings, however, were reported to have been poorly attended, the import of which is equivocal — apathy, assuredness of passage, time conflicts, poor advertising, etc. Noteworthy, too, is that except for the three students on the committee, the student body as a whole knew precious little about the formulation or content of the change. I would venture to say that at press time students, at best, knew that a change had occurred and were slowly gleaning the details by word of mouth. Needless to say, the student body had no part in the approval process. In the interest of fairness, I should reiterate that the old curriculum remains in effect for the currently enrolled student, so that the student interest level was rather low.

One of the main distinctions between the new and old curricula is the predominance of longitudinal courses in the former and block courses in the latter. We had basic longitudinal courses in the first semester and in the second and third semesters had blocks which dealt with most of the salient features — physiology, histology, pathology, pharmacology — of one organ-system at a time, such as cardiovascular for five weeks and renal for three weeks. You will have about four courses running concurrently, and, with the exception of pathophysiology, they will not be organ-system oriented. I would say that the blocks have been well received by most students. The alleged disadvantage of the blocks is that students are exposed to a subject once, in a short period of time, with little repetition or time for assimilation. Some believe longitudinal courses will remedy these "shortcomings." The blocks have the advantage of integrating the teaching of each system. The longitudinal approach tends not to tie the various disciplines together as well, but the pathophysiology course should help serve that purpose. I wish I could let you decide for yourself between the two modes of teaching, but the choice has been made for you.

Among the possible advances of the new curriculum are the potential variety and combinations of courses in each discipline leading to the M.D. It is hard for me to be very specific about this aspect, because the actual courses have



*Lab session on rat lung during respiratory block of HMS I.*

yet to be designed. Generally, flexibility would seem to be a good thing but tends to be overshadowed somewhat by most students' not having advanced standing. Therefore, for the first three semesters most of you will be inclined to take all of the introductory courses. If, in fact, there will be more than one introductory course in each area, as there is now in biochemistry, that will create a distinctly advantageous educational situation. If you go slower than your peers initially or have to drop a course, which is permitted within the first half of a course, you will be able to catch up without losing a major block of time.

The thrust behind the three required nonclinical electives has been the repeated complaint by clinicians that we have not been sufficiently well prepared in basic science before entering the clinics. Naturally, the basic scientists are pleased by the additional requirements. My impression is that students generally do not take too kindly to the *requirement* of additional basic science. True, many students have at some point elected to return to the classroom or do lab work. Clearly, however, not enough students have had that urge to satisfy the policy-making bodies of HMS; hence, the new requirements. I am not sufficiently far along in my med-

ical education to know how well or poorly prepared I am for the clinics. Nevertheless, I think the decision to return to the classroom should be an individual one. In any event, you may take classroom work while you are doing clinical rotations; Tuesday and Thursday afternoons will theoretically be free during most clerkships. This can be an excellent opportunity to integrate clinical and classroom exposure.

Another controversial point is the area of concentration, which grew out of the feeling among faculty members that students have tended to take a smorgasbord distribution of electives with "little method to their madness." We have about 14 months of unrestricted elective time during which some have created their own areas of concentration and others have tried to get a taste of everything. Strong arguments can be made for either approach. One positive feature of the area of concentration is that it may engender new courses in established areas, thus adding diversity and decreasing attrition due to under-subscription. If, as is claimed, there will be innumerable combinations of courses acceptable for fulfillment of the area of concentration requirement, then hopefully it will not restrict elective freedom.

Supposedly, the area of concentration will familiarize the student with the intellectual process of indepth learning. One argument offered against the requirement was that because most Harvard Medical students do eventually specialize, they need not narrow their focus as undergraduates. The response was that students hopefully would choose to concentrate in a field outside their eventual area of specialization. This would allow one to broaden rather than narrow one's horizons. This notion rests heavily on academic idealism whereas the pragmatism of many students would dictate spending this time within their area of interest. What can I say? I hope that you love learning for learning's sake enough to follow the first course of action.

It is expected that the requirements in the behavioral and social sciences will provide impetus for the development of desperately needed substantive courses in these areas. Of necessity, a comprehensive course in pharmacology will be offered which should be an improvement over the rather diffuse exposure we received. Most of us regret not having had an organized pharmacology course. In addition, the advisory system is being revamped in order to provide greater continuity in academic counseling. The 15 or so advisors to be elected presumably will be "experts." Until now, any faculty member could act as an advisor, and the quality of advice offered by individuals has been grossly disparate. Another advantage of this curriculum is

the opportunity those with strong science backgrounds have to push ahead. Students who receive advanced standing will be able either to take advanced courses in the area of their expertise or electives in any area or to get into pathophysiology and the clinics earlier.

Finally, let me leave you with one thought — don't be overwhelmed by Harvard Medical School. It is an impressive institution with good faculty and facilities, but you were selected because you are good; and as long as you keep yourself together, you should be able to cope with anything.

## The Clinical Year and Beyond

by Martha J. Macdonald '74

*Curriculum controversies always seem to focus on the first two years of medical education. Students during their basic science training have very little first-hand contact with patients. Therefore, it becomes possible to lose sight of the object of classroom teaching. Martha J. Macdonald '74, now a pediatric resident at the Massachusetts General Hospital, looks at what it is like to be a clinical clerk in a Harvard teaching hospital.*

After two years of medical school courses (some of which you will think exceedingly irrelevant), the clinical years will burst forth with the promise of relevancy — after all, the clinic is what being a doctor is all about. You will find yourself in white jacket, stethoscope in one pocket, black notebook (filled with everything you should know about medicine but can't retain in your head) in the other pocket, and black bag in hand being addressed as "Doctor \*\*\*\*\*," and at last that means YOU! You will have your own patients, and for the first time since entering medical school, your responsibilities will be to others.

You will be a functioning and important part of the ward team composed of residents, interns, and medical students. The care received by patients assigned to you will be affected by what interest you show in them — not only in their diseases but as people as well. Your *raison d'être* no longer will be only to learn as much as you can. You will, for most of your core clinical clerkships, live the life and keep the hours of a house officer, learning on your feet from visits (staff physicians assigned to your ward team) and, to an even greater extent, from interns. You will do "scut" work — drawing blood, looking at



*Pathology session during cardiovascular block of HMS I.*



**“Some students arrive at HMS with a career plan in mind, but for most the clinical rotations determine what specialty is pursued.”**

urines and doing anything else the intern is too busy to do. That means taking night-call every third evening, every third day in rotation. It is an exciting year which will leave you, albeit exhausted, on the threshold of internship, transformed into a competent and useful physician-to-be.

Unlike previous classes, your class will be asked to concentrate in a particular area during the third and fourth years. This “concentration” will include more basic science courses, perhaps research, and further clinical courses. Classes before you were not required to have any specific field of concentration. Some pursued well-defined research projects, but the majority took one-month, subspecialty, consult clinical courses such as cardiology, infectious disease, or hematology. This style of elective choices, also known as

“berry picking,” left many disenchanted with knowledge gleaned per time invested. Favorites among these subspecialty courses have been family practice, triple threat (eyes, ears, nose, throat, and dermatology all in one), advanced medicine, radiology, the infectious disease one-month lecture in March, and psychiatry. Courses to be avoided at all costs will vary each year. It is a good practice to check with some friendly upperclassmen before committing yourself to courses that may be disastrous. Harvard hospitals include the Massachusetts General Hospital, Peter Bent Brigham Hospital, Beth Israel Hospital, Children’s Hospital Medical Center, Boston Lying In, New England Deaconess Hospital, Cambridge Hospital, and the Mt. Auburn Hospital. Courses vary in each hospital — e.g. cardiology at the Mt. Auburn Hospital might prove to be most valu-

able while cardiology at the MGH might be a bad investment. Some students elect to take courses at other medical schools in other states or countries. Obstetrics-gynecology and neurology are particularly popular in London. Students planning on interning outside the confines of Boston find that pursuing electives in hospitals they are considering acquaints them with the hospital and improves their chances of being offered a position.

Before writing this article, I polled HMS ’74 and received about 25 responses. Student criticisms of the clinical years at HMS are many. Few find them, as did one HMS ’74, “the happiest time of my life.” Even the most motivated students complain that the experience is tense and competitive with personalities playing a very important role in the value of the experience — not to mention the evaluation received at the end of each course. Teaching is too often scanty and unorganized without emphasis on public health measures or on the delivery of health care. Time invested is maximal but often inefficient. Yet the clinical resources at Harvard Medical School are vast, unique, and, for many, the reason they chose HMS.

Beyond the clinical years lie internships or residencies. Most HMS graduates get an internship at a hospital that ranked in their top three choices. Many stay in Boston at one of the Harvard hospitals. Another large contingent travels to the West Coast. The majority of the Class of 1974 took internal medicine internships (96 students out of a class of 174); surgery (24/174); pediatrics (20/174); rotating internships (11/174); family practice (8/174); and psychiatry (8/174). Three students elected to take pathology residencies; two obstetrics-gynecology; one radiology; and one neurosurgery. Some students arrive at HMS with a career plan in mind, but for most the clinical rotations determine what specialty is pursued. Trends this past year have shown a decrease in the popularity of surgery and an increase in the popularity of the new specialty family medicine. Options open to medical school graduates include research at the National Institutes of Health (decreasing in popularity with disappearing draft obligations) and fellowships in a variety of subspecialties following one or two years of in-hospital training.



*Dr. Walter Gamble, assistant professor of pediatrics, holds a clinic during the cardiovascular block of HMS I.*



# The Harvard-MIT Program in Health Sciences and Technology

by Kenneth R. Bridges '76

*Most alumni are unaware that each medical school class is subdivided into two groups. The overwhelming majority of students go through the standard curriculum, as outlined in the previous article. But for several years now, an elite group of 25 students has enrolled in the Harvard-M.I.T. Program in Health Sciences and Technology. They attend separate classes and concentrate more on the basic and physical sciences. Kenneth R. Bridges '76, enrolled in the program, focuses on a special type of medical education that three days per week is "on the other side of the River."*

Rapid growth in the medical sciences has created a need to revise the traditional concepts of medical education. The Harvard-M.I.T. Program in Health Sciences and Technology (HST) is the product of this need. It realizes that modern physicians must be able not only to understand and to control the complex machinery of medical therapy, but also to recognize the implications of the use of such therapy in the lives of their patients.

The HST program as it presently stands is a curriculum aimed at students with strong backgrounds in the quantitative sciences who are interested in maintaining that same type of rigorous approach while pursuing the M.D. degree. Just as during the 1930s biological chemistry was making its debut in medicine with the promise of unfolding a whole new realm of understanding of disease, so today other areas of science, particularly mathematics, physics, and engineering, present a great hope of creating new inroads into many of the problems still apparent in human pathology. The structure of the program opens up the possibility of doing elective course work at M.I.T. and Harvard in both undergraduate and graduate departments during the course of medical training. Students admitted to the HST program who have further work to do on undergraduate or graduate degrees can continue with a combined degree program, while other students can enroll for elective courses. But one important aspect of the program which has yet to reach its full de-

velopment is the creation of an awareness of the profound social implications of medical practice.

The need for this type of medical school program was recognized as early as 1966 when Dr. James Shannon, then the Director of the NIH, proposed that a medical school be founded at M.I.T. with \$60 million in initial capital supplied by the federal government. At about the same time, Dr. David Rutstein and other faculty members at HMS approached Dean Robert H. Ebert with a proposal for the development of a major biomedical engineering program as an adjunct to the curriculum. Talks between the Dean and Dr. Jerome Wiesner, then Provost of M.I.T., led to the creation, in 1967, of a Harvard-M.I.T. faculty committee to explore the possibility of joint effort in health research, delivery, and education. The committee met for two years and issued a report expressing the belief that fruitful possibilities existed and that a concrete planning effort should begin. Dr. Irving M. London, then professor of medicine at Albert Einstein Medical School, was chosen as chairman of the planning committee, and in the spring of 1970, a proposal was presented and accepted by the faculties of M.I.T., HMS, and the Harvard School of Public Health. Dr. London remained as director of the HST program, and the first class was admitted in September 1971.

An outline of the structure of the program can be found in the catalogue, but

there are a few aspects of the course arrangement that deserve particular attention. First, the longitudinal course schedule allows students to participate in other courses at Harvard and M.I.T., as stated previously. In addition, this arrangement allows time for review of course work over the semester so that the material can be learned more thoroughly, at the same time permitting integration of presentations in concurrent courses. Second, all courses have a strong emphasis on student involvement. An example of this is the student seminar in which one or two students, with aid from a faculty advisor, do extensive study in some particular area and then present a 15 to 20 minute discussion of the topic. Such seminars not only are informative for the class but also increase group interaction. And third, the neuroanatomy course included a dissection of a human brain which was really an irreplaceable teaching device. Topologically the human brain is a complex organ, and it is difficult, if not impossible, to understand its structure solely from photographs and drawings. Students were free to touch, examine, and dissect one or more brains until they felt that the concepts were implanted solidly in their minds. This is an example of an important component of the program, that is, making students key figures in their own educational experience.

Most of the faculty members take a very strong interest in the students and in the program and go out of their way to learn not only the names of the stu-

dents but also a little about them personally. Since most courses have a relatively small "core" group of faculty members, there is continuity in the teaching, and the familiarity between the students and instructors that results helps break down much of the stuffy formality, which might otherwise pervade. Most students are pleasantly surprised when they find that their professors not only make themselves available but even actively encourage students to come in and talk. Due to student feedback, a student-faculty Course Evaluation Committee was created specifically to review the courses at the end of each semester. Practically the only negative point about the faculty is that it suffers from the same problem of composition as the HMS faculty as a whole, in that there are very few women or minority group members. This is a problem which must be approached from a Medical School-wide perspective before it can be dealt with adequately.

Like the faculty, the student body in the program is small, with only 25 members per class. Most of the students have done their undergraduate work at either Harvard or M.I.T., but students from other schools have been admitted to the program and have adjusted well. One hindrance to the expansion of the base from which students are drawn is that the HST program is so new that few people from other universities and colleges are familiar with it. But this problem should correct itself in the future as descriptions of the program are included in catalogues and more people come into contact with students and graduates. There is a remarkably wide range of interests among the members of the program, representing such diverse fields as physics, virology, economics, and anthropology. But the one common interest shared by everyone in the program is learning a rigorous, quantitative approach to medicine and putting this approach to work in whatever areas they choose.

There are a number of on-going activities that add personality and individuality to the HST program. One of these is the Harvard-M.I.T. Evening Seminar Series. The evening consists of dinner for faculty, students, and friends at either the M.I.T. or the Harvard Faculty Club, followed by an informal talk by a distinguished guest

speaker. Speakers thus far have included Dr. Carroll Williams, professor in the department of biology at Harvard, Dr. George W. Thorn, Hersey Professor of the Theory and Practice of Physics, Emeritus at the Harvard Medical School, and Dr. Francois Jacob, professor of molecular genetics at the College de France and Nobel Laureate. Also, small parties at the ends of courses have been quite popular, with members of the class and instructors taking some time to relax and get to know each other a little better. Several courses have had regular coffee and cookies breaks. And one day in the gastroenterology course was particularly pleasant when one of the instructors brought in wine and cheese for everyone.

All of these factors have added up to produce a program that is exciting and innovative yet personal and quite easy-going. Medical school in general has a notorious reputation as a

pressure-cooker in which students grapple and gouge their way through, following only the law of the jungle. I have found very little of this in the HST program. Students work hard because that is what they have been trained to do over the years, but the air of acrimonious competitiveness has been largely absent. By the same token, most faculty members have taken a serious yet relaxed attitude toward the material and have discouraged competitiveness among members of the class while encouraging individual achievement. These factors have added together to produce a very high level of contentment with the program. With most new institutions or programs, there is a hard-core group who complain about any-and-everything. But with the HST Class of 1976, anyway, no one I know regrets coming into the program. The Harvard-M.I.T. program is young and will continue to improve, but already it has taken great strides toward achieving its goal.

## A Non-Collective View of the Biosocial Curriculum

by Paul S. Appelbaum '76

*The original version of Perspectives contains an article reprinted from the November/December 1973 Alumni Bulletin entitled, "A Collective View of the Biosocial Curriculum." It is written by the Biosocial Curriculum Collective, a group composed of all the student members, except Paul S. Appelbaum '76, on the Dean's Task Force on a Biosocial Curriculum. The Collective concludes that Harvard Medical School should develop a separate track of courses for students interested in biosocial medicine. Among its most controversial proposals is Harvard's training of community physicians who would not have direct in-hospital responsibility for their patients. The article is thought-provoking and worth reading or re-reading in light of the following dissenting viewpoint.*

*The fact remains that there has been very little progress in developing a biosocial curriculum. Efforts seem to be stymied because of unnegotiable differences between the Biosocial Curriculum Collective and the faculty members on the Dean's Task Force on a Biosocial Curriculum. Paul Appelbaum believes the Collective should yield somewhat to help make a biosocial curriculum a reality. He considers critically the bureaucratic machinations of both the students and the faculty.*



For many years the biological and social sciences have stood as antitheses at distant ends of a spectrum of knowledge. Biological science was "hard" science which could be directly used to improve human life and foster human "progress." Social science was a "soft" endeavor, at best the concern of a few imaginative intellectuals, at worst a sophisticated blarney. And so things stood until some innovative investigators applied their experimental techniques to measure the overlap between the biological and the social in the field that lent itself most to such analysis — medicine. The results were intriguing.

It was found that years of pathophysiological training were being wasted out of ignorance of sociology — it was hardly productive to instruct a member of a cultural group accustomed to frequent small meals during the day to "take one pill before each meal" and expect the result to be three evenly spaced doses. Vast numbers of patients were being denied available medical treatment because of lack of knowledge on the part of the physicians of political economics. Drugs, appliances, and therapies were not paid for by public assistance programs and had little chance of being purchased by poverty-level patients. Simple insensitivity to the urgencies of human existence delayed the healing of disease. A woman who alone supported and cared for her five children was quite unlikely to follow the advice of a physician who instructed her to "stay off your feet for a few days." Results such as these, and the findings of low levels of compliance with physicians' instructions in many ethnic groups, suggested that the achievements of our research laboratories were being squandered by medical cadres with advanced scientific, but primitive social, training.

The widespread feeling that our current system of medical education was producing physicians with central blind spots when it came to patient care led, in recent years, to many proposals for the institution of a "Biosocial Curriculum" — a course of study that trained physicians in the behavioral and social as well as the medical sciences. Medical leaders across the country grew fond of declaring that therein lay the future of medical training. Yet, despite the fact that such statements had

become commonplace and that Dean Ebert himself had expressed such views, Harvard took no action to establish a biosocial program of study. Then, in the spring of 1973, a group of dissatisfied minority students formed the Third World Caucus and demanded a commitment from the administration to develop a Biosocial Curriculum. Months of demands and meetings culminated in the establishment of a Task Force on the Biosocial Curriculum. The Task Force was chaired by Dr. Leon Eisenberg, chairman of the Harvard Department of Psychiatry, and was composed of ten other faculty members and ten students. Of the students, five were members of the Third World Caucus, one was a representative of a small group of "poor white" students, and four were selected at random from a pool of interested volunteers.

This heterogeneous group was charged with the responsibility of planning a Biosocial Curriculum which would then be submitted to the dean and the faculty for approval. Yet, even now substantive work on a curriculum has not begun, and the committee is mired in a miasma of antagonisms and philosophical incompatibilities. It may well be instructive to consider what factors, far from unique to Harvard, have stymied the drive for a Biosocial Curriculum; the stakes for medical care in the country as a whole are too great to permit such a failure to be repeated.

If we accept the premise that the deficiencies in medical education outlined above are real, then it must follow that the training of physicians — all physicians — should be altered to eliminate the deficit. The consulting academic neurologist has as great a need for effective communication with patients as the primary physician in a ghetto clinic. The advice of the cardiac surgeon must be as realistic and as scrupulously adhered to as that of the general internist. To minister effectively to the sick, all physicians need the training in sociology, economics, and psychology that a Biosocial Curriculum would provide. This suggests, then, a drastic overhaul of the preclinical training period, requiring either elimination of current offerings or extension of classroom time for additional social science instruction.

There are two reasons why such a radi-

cal alteration in medical education cannot be accomplished at Harvard. First, the nature of faculty politics here (superbly analyzed in "Medical Education: Harvard Reverts to Tradition" by Samuel Z. Goldhaber HMS '76, *Science* 181: 1027-32) is such that an attempt to abbreviate any current offerings would arouse the fiercest territorial instincts of each department. Already deprived of teaching time by the "core curriculum" innovations, the preclinical faculty would never consent to an even greater curtailment of their influence on medical studies. Second, any expansion of the current preclinical period would be consumed by those Quadrangle departments with the most political leverage. This is precisely what has happened in the latest curriculum revision, which resulted in the abandonment of the "core."

If a change in the basic course of instruction is clearly out of the question, how, then, did Dean Ebert intend the Task Force to meet its goal of designing a distinctive program? The dean fell back on the model established by the Harvard-M.I.T. Program in Health Sciences and Technology: *de novo* construction of a small program with independent admissions and separate courses designed to produce a different kind of doctor. Students admitted to the Biosocial program would be expected to become "physicians interested in primary care and community medicine and in behavioral science." The new general practitioners and community psychiatrists were to be insulated from the rest of their classmates in a separate "track" from admission to the completion of preclinical training, and perhaps beyond. Providing adequate patient care was thus defined as the province of a special type of doctor outside the realm of the vast majority of Harvard graduates.

The theoretical justification for this position was provided by Dr. Daniel Finklenstein, a Harvard psychiatrist who has spent many years exploring the selection and training processes of physicians. His studies led him to define three types of medical students: student-practitioners, student-psychiatrists, and student-scientists. The first two types of students had both scientific and social interests, intended to pursue careers in primary care of the sick, and, hence, would benefit from the



Biosocial Curriculum. The third group, comprising the overwhelming majority of current students, had a narrow scientific orientation and would inevitably seek academic and subspecialty careers. From this schema Funkenstein drew two curious conclusions: first, since the student-scientists were not interested in the knowledge that the social sciences had to offer, any attempt to present it to them would be wasteful; and second, he could select, at the time of admission to medical school, those students who would later become primary-care physicians. This deterministic viewpoint excluded from the Biosocial Curriculum precisely those students who were most in need of it and threatened to bias the program's admissions against whites, especially white males.

This is the background against which the Task Force began to work. Given this situation, a group of individuals dedicated to the goals of the Biosocial movement could have produced a workable, if far from optimal, document. Several of the faculty members of the Task Force, however, were far from dedicated. Many failed to attend a single meeting, and few were present at all of them. It was when they were present though, that the greatest difficulties arose. Immediately it became apparent that a large proportion of the faculty members was not convinced of the desirability of the new curriculum. A committee formed with the notion that it "should explore the planning of a . . . [Biosocial Curriculum]" now found its first task was convincing many of its members that it should exist. The questions raised by the doubters reflected the heterogeneity of committee viewpoints: Weren't general practitioners anachronistic? Couldn't a nurse-practitioner or physician's assistant do the job just as well, if not better? Wouldn't a national program of Health Maintenance Organizations render the graduates obsolete? And, of course, where will we find time to include the necessary courses in the preclinical years?

The student members of the Task Force, faced with questions such as these, sensed a double-cross. They were there because of their commitment to the idea of joining the biological and social sciences, and they had assumed the faculty motives were similar.

But it seemed that some of the faculty members had been appointed to the Task Force simply to delay the proceedings, slowing it in a quagmire of conflicting philosophies of medical practice. This was a crucial juncture. If the students had adopted a practical policy of pushing ahead with the substantive work of the committee and leaving philosophy at the sidelines, the Task Force could immediately have begun productive work. This they did not do. Instead they accepted the gauntlet flung by the faculty members and decided to win the ideological battle before proceeding to concrete tasks.

To find the reasons for this strategic decision, we have to turn back to the composition of the student representatives. Two of the four randomly selected students never appeared, and an additional Third World student and a student with close ties to the Third World Caucus took their places. Most of the students were political "radicals" whose approach to politics had been developed in the campus rebellions of the late 1960s. They viewed the Task Force not as a collection of individuals who were present to exchange viewpoints and reach a consensus through open debate and discussion but as a negotiating forum where two inherently antagonistic groups met: the students, with a common proposal designed in advance, and the faculty, whose only option was to accept the student propositions *in toto*. For the purposes of these negotiations, all the student members of the committee except I formed the Biosocial Curriculum Collective. The common front the Collective presented inevitably turned committee proceedings into an adversary process.

An interesting sidelight, indicative of the temper of committee proceedings, involved the author, the only student committee member not part of the Collective. Following an early meeting of the Task Force at which he vigorously opposed a thesis offered by a leader of the Collective, he was the object of a most unusual midnight visit. Two members of the Collective arrived to inform him that they had listened again to his remarks on the tape they had made of the meeting and had decided that his commitment to a Biosocial Curriculum was severely in doubt. Seating themselves on his floor, they proceeded to suggest that his involvement with the

committee was for the benefit of his internship application and that if he continued to verbally oppose Collective positions, resignation was his only honorable option. Nothing came of the half-hour visit except a heightened appreciation of committee dynamics.

The Collective developed a theoretical stance in reply to the faculty challenge and in accordance with their ideological inclinations. Their comments were published in a carefully documented "Report of the Biosocial Curriculum Collective on Biosocial Medical Education." Their report delineated the nature of the physician they expected the program to produce and justified each element of their proposal. Their goal was to deliver primary care in a community of which such a physician would be a resident and actively engage in political actions. Practice would be limited to out-patient medicine and care of hospitalized patients would be undertaken by hospital-based specialists. The physician would be singularly concerned with preventive medicine.

Given this theoretical groundwork, the faculty responded to what they felt were weaknesses in the analysis. Even faculty members who had previously shied away from the teleological controversies felt obliged to attack what they saw as weaknesses in the Collective's position. They argued that the Collective's end-product was undesirable. The student would be trained to work in a system that did not exist and might never exist, instead of being trained to make the best of opportunities in the current structure. The continuity of patient care would be threatened by denying hospital privileges. The new physician would be forced into an inflexible social and personal situation by mandating residence in the community of one's practice. Commitment to and productivity in medicine would be diminished by time spent in political endeavors that could be better handled by others.

The Collective was caught in a logical dilemma. To assert that it was right and the faculty was wrong, when both were arguing unprovable notions, would be viscerally satisfying, but would doom the future of the committee. Yet the only way out of the maze was to argue that the Biosocial Curriculum would be beneficial for everyone who completed it. This was counter to initial contentions

that the social and political structure within which a physician practiced was the most important determinant. To accomplish the shift would have required the Collective to begin to approach the Biosocial question from the educational, instead of the political, perspective.

Whether the Collective could have negotiated such a shift or whether some other way would have been found out of the committee's dilemma can never be known. When theoretical disputes sapped its momentum, the Task Force simply stopped meeting in the fall of 1973. Ostensibly, subcommittees were formed to design individual parts of the curriculum, but nothing has been heard from any of them.

The object lessons of this case study are relevant to a wide range of interactions at HMS. The faculty are concerned with prestige and with power. Like any other middle-level bureaucracy, they operated with a strong presumption in favor of the *status quo*. The core curriculum was abolished six years after its inception because the basic science faculty had never been reconciled to the loss of power that its adoption entailed. They had, moreover, never been given a reason to want it to succeed. This concern with power can, however, be turned to advantage. For if the faculty are given a stake in the success of a program, if they are made responsible for its development and implementation and held accountable for

its failure, then their considerable power can be mobilized for innovation. Few are the instances in which the key to success of a proposal lies elsewhere; alienation of the faculty almost always assures defeat.

The actions of the Biosocial Curriculum Collective belie the assertion that the age of ideology has come to an end. Once more, the unwillingness of proponents of radical change to place their ideology aside and concentrate on the immediate task has led to the alienation of potential allies, tactical deadlock, and strategic defeat. And there it stands, much as it did a year-and-a-half ago, with Harvard still making no effort to train the complete physician.

## Part III - Diversity

### Married Students

by Mark J. Greenwald '76

*The purpose of "Part III — Diversity" is to heighten awareness of the many different types of students at Harvard Medical School. One of the neglected minorities, especially during the first year, is the married medical student, who simultaneously must face new family as well as academic challenges. Mark J. Greenwald '76 gives a brief overview of various problems a married couple may encounter.*

#### Social Life

Social adjustments can be difficult for the married medical student during the first year. You will find that your fellow students who live in Vanderbilt Hall get to know each other rapidly while you will become acquainted with the class much more slowly. You probably will also find that your social needs and interests are quite different from those of your unmarried classmates. The best approach combines patience and a certain amount of aggressiveness in meeting people. Amphitheatre C provides little opportunity for social contact, but through the small lab sections you will get to know at least a few students early

in the year. Eating lunch in Vanderbilt Hall can be a good way of expanding your circle of acquaintances. When you enter the clinic in the second year, the learning situation becomes much more intimate, and friendships develop quickly.

During the course of the first year you gradually will get to know the other married students in the class and undoubtedly will find that they have shared the same sense of initial isolation. The sooner you discover each other the more pleasant your first year will be. Don't hesitate to take the initiative in

this matter — you can be confident it will be welcomed by your fellow married students.

#### Spouses & Children

Job hunting can be a discouraging experience for the medical student's husband or wife because Boston is so overpopulated with college graduates. Many positions that elsewhere would go to persons with a B.A. are filled by those with a Master's or more. Teaching, in particular, tends to be over-



subscribed, although openings do occur. There are always numerous secretarial and clerical posts available in both businesses and the local universities. University pay scales tend to be lower than those of private enterprise; but the atmosphere is more comfortable, and there may be opportunities to take courses at little or no charge. There are also frequent openings for medical technicians in the local hospitals for which no previous experience or

training are required. Apply for these directly to the hospital, not through the Medical School, and mention that you are a medical student's spouse.

The Boston area abounds in high quality day care centers and nursery schools of every educational persuasion as a consequence of the large concentration of academic and professional families. For information about these, contact the Child Care Resource

Center in Cambridge or the local Department of Public Health.

Presently plans are being formulated by the office of student affairs to assign each entering student an upper class tutor, and hopefully all the married students will be assigned married students as tutors. Feel free to ask them any questions you have and to discuss problems you encounter in adjusting to life in Boston or HMS.

## Women

by Maria C. Savoia '76

*Maria C. Savoia '76 devotes much of her time to promoting the rights of women in medicine and to combatting subtle and blatant manifestations of sexism. She works closely with Dr. Mary Howell, Associate Dean for Student Affairs. Maria Savoia's article presents the historical roots of sexism at Harvard Medical School.*

"What's a nice girl like you doing at a place like this?"

"For vehemence and personal animosity almost resulting in disaster," writes Thomas F. Harrington in *The Harvard Medical School, A History, Narrative and Documentary* (1905), "no recent controversy equals that in 1882 over admission of women to the Harvard Medical School."<sup>1</sup> Until the beginning of the 19th century, women appeared in American medical history principally as midwives, but after the establishment of the first medical school for women in Boston in 1848, women began to seek formal training at other established medical colleges. In 1878 Harvard was offered \$10,000 by a prominent Boston family if it would make available its advantages to women on equal terms with men. This offer prompted a resolution "favoring educating women in medicine, providing a sufficient sum of money (\$200,000) could be obtained to warrant the Corporation in doing so."<sup>2</sup> Although 19th century feminists apparently sought to raise this sum, on May 24, 1879, a revote deemed it "detrimental to the interests of the School to admit women."<sup>3</sup> When the question was again raised in 1882, a vote of 13-12 denying women admission "prevented the resignation of the whole Faculty."<sup>4</sup>

The question surfaced for a final time in 1943, nearly a century after the first woman had graduated from an American medical school (Elizabeth Blackwell received her M.D. in 1847 from Hobart)<sup>5</sup> and just two years less than a century after the first proposal to admit women was submitted to the President and Fellows of Harvard College. On April 2, 1943, in accordance with the recommendations of a faculty committee, the Faculty of Medicine voted to recommend to the governing boards that the admission of women be authorized as an immediate and permanent policy and that "the proportion of women to men admitted each year be decided by the Committee on Admission solely on the basis of the quality of the applicants."<sup>6</sup> On June 5, 1944, the governing boards voted to approve the recommendation of the faculty, and 12 women were admitted as members of the Class of 1949.

The percentage of women admitted to HMS remained relatively constant over the next 20 years. Approximately five years ago, concomitant with the revitalization of the feminist movement the number of women medical students began and has continued to rise. There are 19% women in the Class of 1975, 23% in the Class of 1976, 27% in 1977, and 33% women expected in the Class

of 1978. Although these percentages are above the national mean of women accepted by medical schools, no admissions committee should rest comfortably until their admissions statistics reflect population statistics.

Is there discrimination against women at Harvard? Margaret Campbell, M.D., in her book *"Why would a girl go into medicine?" Medical Education in the United States: A Guide for Women*, states "It appears that all medical schools exhibited some degree of discrimination against women students, if only because discrimination against women has been and is the accepted pattern in our society. Bias and prejudice against women entering a man's profession take their own special forms, but they are, in the end, only particular manifestations of the more generalized bias and prejudice shown to all women."<sup>7</sup>

For most, simply being a medical student is clearly more significant than being a woman medical student; men and women alike experience the same terror before the first biochemistry exam, the same trepidation interviewing their first patient. But women do face barriers of a sort men do not. They must cope with demeaning sexual stereotypes; they often juggle the de-

manding responsibilities of family and career without the help of an "at home" spouse; and they may feel more acutely the plight of women patients who seek care from a system that tends to make derisive assumptions about women's psyche and capabilities.

Many women medical students have found it helpful to join other women in the medical area. The Harvard Medical Area Women's Group is a loose association of faculty, house officers, students, and employees which began meeting in 1971 and seeks to foster discussion about and improvements of the status of women at Harvard. From this group came the proposal to establish the formal 26 member Joint Committee on the Status of Women at the Harvard Medical School, Dental School, and School of Public Health, appointed in 1973 by Deans Robert Ebert, Paul Goldhaber, and Howard Hiatt. This official Harvard committee, also representing the interests of women students, faculty, house officers, and employees, is documenting the current situation for women and making recommendations. Both the Harvard Medical Area Women's Group and the Committee on the Status of Women strongly desire student participation and impact. Certainly the situation will improve as more women enter the medical profession, find support in each other, and seek solutions to commonly shared problems.

#### Footnotes:

1. Thomas F. Harrington, *The Harvard Medical School, A History Narrative & Documentary* (3 Vols., New York: Lewis Publishing Co., 1905) p. 1217.
2. *Ibid*, p. 1224.
3. *Ibid*, p. 1234.
4. *Ibid*, p. 1217.
5. *Ibid*, p. 1218.
6. George Packer Berry, M.D., Foreword to "*The First Decade of Women*" in the *Harvard Medical School* (Boston, Harvard Medical Alumni Association, 1959) p. 11.
7. Margaret A. Campbell, "*Why would a girl go into medicine?*" *Medical Education in the United States: A Guide for Women* (Margaret A. Campbell, 1973) p. 1. (Valuable and interesting reading for any woman contemplating going to medical school. Copies are available from Ann O'Shea, Dept. SL, 320 West End Ave., Apt. 6B, N.Y., N.Y., 10023.)

## Third World Students

by Kenneth R. Bridges '76

*To endeavor to write about such a diverse group as Third World students is to accept a most difficult challenge. Yet Kenneth R. Bridges '76, a black medical student involved with the Black Health Organization, has written a perceptive and comprehensive article. He has worked for the rights of Third World students with Dr. Alvin F. Poussaint, Associate Dean for Student Affairs.*

It is a singularly difficult task to characterize Third World students at Harvard. Not only is there a great deal of diversity among the students; any one person's impressions will be colored distinctly by individual beliefs and prejudices. But forewarned is forearmed. Always keep in mind that you can come to know and to understand Third World students only by meeting, talking, and exchanging ideas with them.

And it must also be kept in mind that the fairly substantial number of Third World students at HMS is a very recent phenomenon. There has been a trickle of Blacks and other minorities through the faucet for a long time, but never enough to fill the basin. In fact, in 1968 there were only five black students pursuing the M.D. degree at this institution. But 1968 represented a year of confrontation both for HMS and for the nation. Catalyzed by four years of Black people's forceful resistance to oppression, spurred by the growing sense of solidarity in the Chicano and Boricua communities, and shocked by the assassination of Dr. Martin Luther King, in May, 1968, 278 members of the student body of HMS sent a petition to Dean Robert H. Ebert in which they expressed a belief that "the response of the white community can act to promote or prevent the further deterioration of life in our inner cities and relations between the races." They called upon the faculty of the Harvard Medical School to establish a high-level, Medical School-wide, fact-finding commission to assess the potential contribution of the Harvard Medical community to the improvement of the lives of the country's poor and disadvantaged. In response to this petition and a letter of

similar tone signed by eleven senior faculty members, the Commission on Relations with the Black Community was created.

Dr. Leon Eisenberg, chairman of the Commission, prefaced the report to the dean with a statement that "all of us have tolerated, if not created, a social structure whose outcome has been racist, whether it was consciously intended or not. To the victim, it mattered little whether the outcome was intended." Proposals were generated by the report to increase "significantly" the number of minority students at HMS, to establish a Health Careers Summer Program designed to give undergraduate minority students an exposure to Harvard via the Summer School in Cambridge, and to provide more effective health care to the Third World Communities through neighborhood health clinics. All of these proposals have been enacted and are still being implemented, with more success in the former two cases than in the latter.

Dean Ebert played a major role in the augmentation of Third World students at Harvard. Although the Commission report focused primarily on the relationship of the Medical School to the Black community, the dean recognized that the attack on existing inequities had to be larger in scope and include all members of the Third World: Blacks, Chicanos, Boricuas (Puerto Ricans), and Native Americans. Associate Dean of Student Affairs at Harvard, Dr. Alvin F. Poussaint, was a key figure not only in the recruitment projects designed to get more minority students into the Medical School but also in the promotion of social and other ancillary func-



tions aimed at attenuating adjustment problems once the students matriculated.

But one important point of clarification must be made relative to the proposal that "disadvantaged" students be admitted to the Medical School. With few exceptions, Harvard has not admitted minority students with admissions qualifications that cannot be matched to those of some of the other students in the class.

In the fall of 1969, 20 Third World students were included in the entering class, and few, if any, of them could be called educationally disadvantaged. A number of them had postgraduate degrees including Ph.D.'s, and all were qualified applicants. One person completed his degree requirements in three years. Third World students who have come to this institution thus far have had the capacity, motivation, and qualifications both to perform and to excel. Many people would hang the "disadvantaged" label on any student from a predominantly Black school, but these students have performed as well as, or better than, their peers from the majority group. Interestingly, there has been a marked flux in the backgrounds of the students admitted to the Medical School. Whereas the Class of 1974 included six persons from predominantly Black colleges in its ranks, the Class of 1977 has only one person from such an institution. With the prospective Class of 1978, the number is back up again, to three. The primary cause for this vacillation is that there are no quotas for Third World students from any school, so that outstanding students are admitted without regard to their undergraduate locale.

Aside from their general academic qualifications, there is little else that can be deemed "characteristic." Minority students at HMS exemplify diversity in background, interests, and goals. A number of the students grew up in middle and upper-middle class environments sharing many of the same educational and cultural experiences as members of the majority group. In contrast, other students came from humble beginnings among the rural or urban poor and have, mainly through their own assiduous effort and fortitude, made their way to upper echelons. And as backgrounds vary, so do aspirations,

each class including in its ranks clinicians and primary care physicians as well as research specialists and academicians.

Variety is also seen in the general experiences which Third World students have while at HMS. The clinical clerkship years are probably more vulnerable to the vicissitudes of human whim than any other aspect of medical education. Interpersonal relationships play a very large role in the course of these years, and, as in any circumstance where two humans come face-to-face, subjectivity is unavoidable. More often than not the student is treated fairly (or at least no differently from anyone else), and no problems are encountered. But in many aspects Harvard is merely a reflection of the society from which it draws its life, and in that sense it can be no prettier than that society as a whole. Some students have gone through the entire four years and have never been singled out for "special" treatment. Others have been less fortunate.

When problems such as these or others occur, it is essential to be able to turn with confidence for advice and aid. And in this area, Harvard excels. There are always people ready and willing to reach out and lend a hand. There is a tradition among the upper-class students of "taking care of our own." Brothers and Sisters are ready and willing to give advice and counsel not only about "shop matters" such as courses, books, and study techniques, but also about more personal matters such as relating medical education to one's ultimate goals in life or avoiding dehumanization while becoming a part of "the medical machinery." For the incoming student, the upperclassman is a most valuable asset. In addition, there are capable and sincere faculty members and advisors who are very helpful in aiding Brothers and Sisters in coping with many of the general problems they might face, such as electives, reading courses, reference material, and the like. And many people willing to take the time have created strong ties with people in the various communities of Boston, broadening their realm of experience beyond the walls of the Medical School.

Others have expanded their interests by participating in student organizations both inside and outside the Medical

School framework. One of these, the Black Health Organization, was founded in 1970 and is designed for the varied interests and talents of Black students in both the Dental and Medical Schools as well as the Division of Medical Sciences (graduate students). One of the primary activities of this organization in the past has been the counseling of undergraduate students interested in the medical sciences and related health care fields. Although activity has centered around the Boston area recently, many members of the BHO have in the past made trips to predominantly Black colleges in the South, and a number of Third World students were recruited to the Medical School. Other programs designed to give disadvantaged students in the Boston area school system greater exposure to science have been implemented successfully. In the past students from the BHO have been actively involved, as well, in the Health Careers Summer Program, both as members of the admissions committee and as academic tutors during the summer.

Another organization which has been extremely active and productive is the Boricua Health Organization. Created in 1972, this organization has been a leader in addressing the particular problems faced by Boricua medical and premedical students. Among the many projects overseen by this group has been a massive mailing campaign of pamphlets, posters, and leaflets aimed at undergraduate students and designed to create and maintain an interest in the health field. This has been followed up by recruitment efforts, especially in areas such as New York City which have large populations of Boricua Brothers and Sisters. The organization has not neglected the great amount of work needed in the Boston area, however, and has participated actively in health and hygiene courses in high schools in the Spanish-speaking community. A youth guidance program has been established to help high school students realize the value of higher education and that careers in medicine are possible. Each medical student takes five or so high school students as tutees and gives them support and information about continued education throughout the year.

Two other organizations that have also made valuable contributions to the Third World community at Harvard are

the Chicano Health Organization and the Native American Tribal Council. The CHO has been involved in recruitment projects and was instrumental in the establishment of a medical Spanish course (outside the Medical School) designed to increase the facility with which medical students or other interested medical personnel interact with Spanish-speaking patients. One problem which the CHO has faced and fairly effectively dealt with has been a reluctance on the part of many Chicano students recruited to come to the East Coast from their homes in the Western states. Most of the students who have come to Harvard have expressed pleasure at finding a closely-knit group into which they could fit but which was still flexible enough not to interfere with their other activities and interests.

But of all the student organizations at Harvard, the Native American Tribal Council has faced probably the most difficult problems. Native Americans have been more poorly represented in the health profession than any other ethnic group in America and have generally received some of the poorest care. Harvard has actively sought to increase the enrollment of Native Americans throughout the University and in this regard the NATC has been crucial. It has played a major role in recruitment and counseling of undergraduate students and has sought to interest more students in careers in medicine. Lobbying for increased financial aid and more administrative attention to specific problems faced by Native Americans at Harvard, the NATC has been important in insuring that the students who have come have remained in school.

Finally, there are a couple of national organizations representing Third World students that have active chapters at Harvard, these being the Student National Dental Association and the Student National Medical Association. In Cambridge the Harvard-Radcliffe Afro-American Cultural Center has acted as a focus for many activities at a University-wide level. Participation in any of these organizations is, of course, completely voluntary, and anyone may put in as much or as little time as he or she pleases. And as with all student groups, you find some people who are very active with seemingly boundless energy while others choose not to become involved at all.

Although the problem of Third World student enrollment at HMS has been vigorously and, to a large degree, successfully attacked, the problem of Third World faculty, which was also investigated by the Commission, has proven to be more refractory to correction. With two exceptions, no medical school in the United States has a large or representative Third World faculty. Harvard University has shown a great deal of reluctance to name Third World people to influential and particularly to tenured positions. The thin excuse that there is a dearth of qualified and/or interested persons available is growing more untenable. But for Harvard there can be no security or assurance of continued enrollment of Third World students until there is adequate Third World representation at the decision-making levels on the faculty and in the administration. Harvard has made great strides in alleviating and correcting many of the injustices that have existed at the University in the past, but it goes without saying that it cannot meet completely its obligations until this most difficult problem is solved.

Lastly, there are people who might question the need to insure that Third World students remain adequately represented at Harvard. Such a query can be answered on three bases. First, and

most obviously, there is a desperate shortage of Third World physicians in this country today which can be corrected only by recruiting actively into medical schools and properly training as many members of this group as possible. Only through such large-scale efforts can Third World people be rescued from poor quality medical care. Second, Third World patients who come onto the Harvard Service at the teaching hospitals feel less intimidated and more relaxed when they see members of their own ethnic group on the medical staff. Often a Boricua, Black, or Chicano medical student can translate idioms or jargon which have puzzled the house staff, thus improving communication and patient care. In addition, Third World students tend to go out of their way to insure that the patient understands the nature of an ailment, thus breaking down some of the doctor-patient cultural barriers. Third, before the coming of the Third World student, the Harvard Medical School was an incomplete entity, because its purest form medicine is a service profession. And no segment of that profession, whether it be the medical school or the community hospital, or the teaching hospital, can be accepted as fulfilling its obligation to society until it represents properly all members of that society.

## Chicanos

### by Juan Montes '76

*Juan Montes '76 expresses the difficulties of adapting to the East Coast from a different cultural and geographic setting. He is from Santa Paula, California and attended UCLA.*

The Northeast could not be further removed from all that is indigenous to the Southwest. One finds a different climate, life style, and people. Consequently, there are few Chicanos in New England. The few permanent Chicano residents in the area are those attracted by employment and financial security. Most are here temporarily as students or professionals participating in educational and training programs and return eventually to their areas of origin. This constant flux of people produces an ever-changing profile of the Chicano population in Boston.

Because Boston is the home of the Pilgrims, the Kennedys, the Old North Church, and Harvard, it is very Anglo-Saxon. There is no pre-existing Chicano identity here and no Chicano culture. One often appears naked in this environment and is confronted frequently with, "Where are you from?" or "What nationality are you?" To answer this question necessitates explaining one's existence and requires more than a simple "I'm a Chicano." For few people in the area know what a Chicano is. But to ignore such a question leads to confusion and misunderstanding.



To aid in one's perspective at Harvard are other Chicano students. Unfortunately, these are few in number. The third and fourth-year students are lost to hospital rotations. Communication is further complicated by regional differences in food, language, and lifestyle among the Chicano students here which can breed misunderstanding and confusion. To prevent antagonism and separation, it often helps to talk of one's experiences, enabling other people to learn and appreciate them in the context of the Chicano awareness. This often leads to the discovery of an underlying core of experience and a bond among the Chicano individuals.

To keep one's sense of reality intact in a nonsupportive environment requires an increased emphasis on one's culture. Fellow Chicano students are sought out; Chicano music is played; Mexican food is craved; Spanish is spoken; and "el movimiento" is ideal. But this struggle takes much effort, and often one becomes overwhelmed by a feeling of isolation and loneliness and what some call "culture shock."

For the Chicanos at HMS, the platform for communication has been a local chapter of the National Chicano Health Organization (NCHO). Through this organization one is linked with the Southwest and *La Raza* (the Chicano people), but it also serves as a forum for communication, planning, and organization for the Chicano students here. Due to the lack of manpower, every HMS Chicano should participate in activities centered around recruiting, admissions, and the Health Careers Summer Program — a Harvard program for Third World students. Other organizations of Chicano concern are Boston Movimiento Estudiantil Chicano de Atzlan (MEChA), which derives its membership from every educational institution with Chicano student enrollment, and the United Farm Workers Union office, a strong and active organization.

It is difficult to find good Mexican food, much less good Mexican music, outside a Chicano residence. There are a number of Mexican restaurants in the Boston area that are both hard on your palate and on your pocket. The most familiar is Casa Mexico in Harvard Square; others include Sol Azteca and Latin-O. The best Mexican restaurant in

the area with the most authentic atmosphere and music is Little Mexico in Manchester, New Hampshire, a restaurant owned by Chicanos. But nothing beats an invitation for a home-cooked Mexican dinner, with Mexican music and Chicano friends.

One soon realizes that the price for a Harvard medical education is great in terms of both money and psychological

hardships. The sacrifices one must make include separation from all that is familiar, learning to cope with a new environment, and continuous self-assertion and struggle to preserve one's identity amidst the Harvard glitter. At Harvard, one endures, survives, and graduates. And it becomes apparent that the knowledge of where one came from and the idea of where one is going transcend the present experience.

## Poor Whites

by Harold Bursztajn '76

*Harold Bursztajn '76 is a poor white whose family took refuge in the United States from Poland. He has been active on the Harvard Medical School Admissions Committee and in Harvard's Health Careers Summer Program. His message to alumni is: "Much more work needs to be done, and opportunities are available."*

The disenfranchised poor of this nation often feel unable to make their problems known to the majority of the members of this active and successful society. In spite of the fact that social consciousness regarding the problems of minority groups has reached perceptible levels, in many respects the health, educational, and economic problems of the Poor White population have been neglected. "Disadvantaged" presupposes a very low income level. This deprivation is reflected in lack of accessibility to health care and difficult entry into the educational system. There is increasing acceptance, even by some minority groups, that these criteria make Poor Whites a disadvantaged segment of our society.

Of the 24 million poor people in the United States, 16 million (70%) are "Poor Whites." It is true that in this country there is a higher proportion of poor minority people than Poor Whites. The legitimate claims of minority groups should never be diluted. However, the huge demand for assistance that exists within the Poor White segment of our society compels us to consider their needs. The point is that if a person in the USA is poor, he or she is probably a Poor White.<sup>1</sup>

Despite the great numbers of Poor Whites, their suffering is voiced in

muffled tones. They have been slow to identify themselves as a "societal problem." Some Poor Whites are reluctant to admit their poverty. And some who are not Poor Whites are reluctant to admit that Poor Whites exist. The resistance I have run into ranges from, "What do you mean by 'Poor White'?" to, "If you're poor and white, it's because you're stupid."

The nation's social consciousness has been raised by the demands of Blacks, Chicanos, Boricuas, Native Americans, and other minorities. The needs have become evident for improved health care, better working conditions, more equitable income distribution, and increased educational opportunities. These needs have prompted an awakened and increasing interest among Poor Whites with regard to their own cultural and socioeconomic problems. They have been challenged either to accept the crippling effect of being "disadvantaged" or to reject and overcome their poverty and its handicaps by increased advocacy for social change. They must put up or shut up.

Harvard Medical School, although slow in assuming its share of responsibility for correcting some of the social injustices, has made a commitment to balancing its student population with regard to minority students and women.

In the class entering HMS in 1974, approximately 20% are minority students, and approximately 30% are women. The Poor White Health Organization has petitioned the Medical School for increased commitment to recruit and admit Poor White students. With the assistance of Dr. A. Stone Freedberg, this group has been successful in getting a few Poor Whites admitted to the Harvard University Health Careers Summer Program that assists them in preparing and gaining entrance to health career educational pathways. In addition to recruitment, Poor Whites have participated in the admissions process at Harvard Medical School. Although the steps are small and halting, it appears that Harvard is moving slowly toward an acceptance of the concept of "disadvantaged" as an economic, social, and educational problem, *not necessarily* a racial one. Discrimination and disadvantage are more than skin deep.

Some Harvard medical students have been involved in improving health care in the surrounding community. In the late 1960s, HMS students joined with a group of people from the adjacent, largely Poor White community of "Mission Hill" to obstruct the proposed construction of a new hospital on the site of the present Peter Bent Brigham Hospital. The community complained that Harvard was "elitist" and had little regard for the health needs of the community it served. As an example, the proposal for construction of the new hospital did not contain plans for new outpatient clinical facilities. These poor people expressed a distinct dislike for the notion that Harvard should expand into their community to train "leaders in medicine," while ignoring neighborhood health needs. As a result, the revised proposal for the Affiliated Hospitals contains some outpatient clinical facilities and begins to recognize the community demands for input.

To encourage applications from Poor Whites interested in the health care professions, the HMS Admissions Committee provided funds for members of the Poor White Health Organization (PWHO) to recruit in Boston's Mission Hill, Appalachia, Chicago, and Nebraska during the spring of 1973. In addition, two PWHO members served on HMS admissions subcommittees as advocates for applicants. For example,

a Poor White applicant who works 40 hours a week may have as much claim to consideration as a candidate who has no need to work and manages to amass the usual amalgam of premed extracurricular activities.

The system within which we live has promulgated the irrational as the rule. "Just as in the midst of life we are in death, so in the midst of sanity we are in insanity."<sup>2</sup> However, rational things are being done for and by poor people. Identify with this struggle, and if you say, "Nobody ever listens to me!" — that is because you are speaking too softly for them to hear.

## Native Americans

by Janice E. Kulick '76

*Janice E. Kulick '76 is the sole native american in the Class of 1976. She was born on the Tuscarora Reservation, part of the Iroquois Nation, near Niagara Falls, New York and returns to visit relatives on the reservation several times each year.*

One of my earliest observations as a first-year medical student was that there were very few Native Americans in my class. In fact, there was but one: me. I felt alone, as any medical student does, but perhaps at times even more so, because I didn't fit snugly into any predetermined group. In many areas I identified with other Third World students, and I joined in the various campaigns of this group. But while we dealt with numerous common problems, there were still many facets of my early medical school experience which were not understood by my classmates.

But wait — even now I hear people saying — "Native American? What do you mean by that?" Basically, a Native American is anyone of at least one-quarter or more "American Indian" blood, preferably registered on a tribal roll. This definition implies a great diversity in a very small population. The backgrounds of the Native Americans vary from those who have lived their entire lives on a reservation to those who have been partially assimilated into the culture of modern United States society. As a result, the spectrum of prob-

Footnotes:

1. According to the National Commission on the Financing of Post-Secondary Education, "the income of families of youths in the 18-24 age group divided as follows: 23% are at the poverty level, below \$6,000; almost 58% fall into the \$6,000-\$15,000 bracket. That leaves less than 20% of all families with children of college age at \$15,000 and above." (From Fred. M. Hechinger, "Class War Over Tuition." *New York Times*: February 5, 1974.

2. Ludwig Wittgenstein, *Remarks on the Foundations of Mathematics*.

lems faced by Native American students ranges from those faced by any medical student to those problems faced by other members of the Third World student population.

The Native American population within the Boston community is greatest in South Boston, where the Dorchester Native American Center plays an organizational role. Other projects include the Native American Clinic at the Massachusetts General Hospital — located on White 1. Harvard University supports a small Native American Program and also maintains the Peabody Museum, with its displays of Native American history and culture. Nationally, there is an association of Native American Medical Students that is closely aligned with the Association of Native American Physicians. Both groups work toward improving the level of health care for all Native Americans.

The Native American at Harvard Medical School accepts a unique responsibility for the medical care of the diverse Native American population.



# Part IV - Coping



Dr. Fred C. Lane (far right), Dean of Students, hears firsthand reports of Internship Matching Day outcome.

## Dynamics of Student-Faculty Interaction

by David W. Nierenberg '76

*David W. Nierenberg '76 has shown leadership in student-faculty affairs. This past year, he was co-chairperson of the Student-Faculty Committee. He has worked hard to draft legislation protecting the confidentiality of student records and to organize a procedure for student evaluations of basic science teaching.*

The Student-Faculty Committee is the "principal representative body linking student and faculty interests." A group of about 30 faculty members and student representatives meets every other week to discuss matters of common interest. The Committee acts as an advisory group, communicating its recommendations and findings to the dean, the faculty, or the appropriate standing committee of the faculty.

The dean chooses the faculty members who serve on the Committee while the students represent different constituencies. Each Medical School class elects two representatives, while each Harvard-MIT class sends one representative. The four classes of the Dental School combine to send two representatives. Several of the student groups

(for example, Harvard Medical Area Women's Group) also send representatives.

Each year the Committee considers major issues and special problems. In the past year the Committee funded student organizations, such as the Black Health Organization; submitted a recommendation to the faculty concerning the confidentiality of student records; put forward proposals on grading; and studied recent trends and changes in the medical curriculum. The Committee has launched a Faculty Evaluation Project in an effort to reward superior teaching in the Medical School. Most recently the Committee met with President Bok and Dean Ebert to discuss the role of teaching in the tenure-granting process.

In short, the Student-Faculty Committee is a group of students and faculty members who try to propose solutions to common problems. That this Committee has the widest purview of all the standing faculty committees with student representatives is both its greatest asset and its greatest weakness. The interest and activity shown by your class will help determine the success of the Student-Faculty Committee in the next few years.

For many reasons, "the students" and "the faculty" today seem to view each other with suspicion and sometimes open hostility. For example, many students felt that "the faculty" was out to get them by reinstituting grades or changing the curriculum (although there were strong arguments made on both sides). And some faculty members were annoyed that students asked questions during class (not realizing that students today are likely to write fewer notes but ask more questions).

I find the situation much like a tennis match, where "the faculty" and "the students" view each other as opponents. Naturally, each side is out to beat the other, to exploit the other's weaknesses, and to force the opponent to play the other's game.

The spirit that prevails when two tennis players are doubles partners is lacking. In that situation, each player realizes the partner's weaknesses. But instead of exploiting them, one tries to compensate, and the partnership works together toward a common goal.

In a nutshell, this is one problem at HMS. The faculty and students do not feel themselves as equal partners working toward a common goal — providing each medical student with a superior and personalized education.

Although neither partner is to blame for this state of affairs, each partner could take certain steps to rebuild a more mutually beneficial relationship. But I will focus on how I feel an incoming student can get more out of HMS.

First, get to know your instructors better. Often a bad lecturer is a terrific section leader. In contrast, an instructor may be unable to handle a section of 24 students but may be a brilliant bed-side teacher. The only way to find out is to

get to know your instructors better. One of the best ways to do this is to invite your lecturer or section leader to lunch or dinner at Vanderbilt Hall. The Student-Faculty Committee will pay for this, and faculty members are usually glad to avoid eating what's in their lunch bags. If you do this early in the course, you often find that the whole tone and direction of your section can be improved to fit your interests and the teacher's special strengths.

Second, take advantage of the particular strengths of each faculty member. I've never met a faculty member who doesn't enjoy talking about his or her specialty or showing it to you. In the block course in reproductive biology, our section was led by a clinician who was a bit rusty in his steroid metabolism. But the highlight of the course (not included in the syllabus) was that on several free afternoons we went with him to the hospital and watched him put the theory into practice. This man was a superb clinician who made the course syllabus come alive.

Finally, on an individual basis, almost any faculty member who is asked will bend over backwards to help a student. If you don't feel that you are getting enough clinical medicine during your first year, pick out a clinician whom you respect and ask if you can follow on his or her rounds one afternoon each week. Chances are 100 to 1 that the faculty member will say "yes," and will be pleased that you thought enough to ask.

In summary, I think that it's time that we stopped thinking in terms of "the faculty" and "the student" as if they were monolithic superpowers engaged in a fight to the death or at least in a fight to win a match, 6-0, 6-0. If we as students can deal with each faculty member on an individual basis, and if the faculty group can recognize the diversity of the students, then we'll see more of a partnership to educate good physicians and less of the antagonism which seems to have developed in the past.

Recent misunderstandings have underscored the need for an official policy on what should be in a student's permanent record and who should be allowed to see that record. As a result, in the spring of 1973, the dean estab-

lished a special committee to draw up guidelines for an official policy that would satisfy the faculty, administration, internship selection committees, and students.

This special committee was a joint subcommittee of the Administrative Board and the Student-Faculty Committee. Its recommendations were amended and passed by both parent committees, and at press time the final draft is awaiting full faculty approval. A copy of the final version, which is now the official policy at HMS, is printed below.

*An academic record and a folder* comprise the student's *whole record*. Each medical student can go to the registrar's office and see the *academic record*, consisting of official grades and comments. Since this is the bulk of a student's *whole record*, an individual actually has direct access to almost everything.

However, material in the *folder* is off-limits to students. The *folder* contains confidential communications from faculty members to the dean or registrar. Any unsolicited faculty letters about a student, either positive or negative, fit into this category. Although the student cannot read these letters, one's faculty advisor can. Thus the student, by discussing matters with the faculty advisor, can learn indirectly about comments in the *folder* and thereby benefit from these comments.

Finally, when applying for first-year residency or internship programs, it is Harvard's policy not to send out transcripts. Instead, a letter of evaluation is written by the student's internship advisor, amended by the dean of students, and sent out under their two signatures. This letter is meant to contain more information than just a transcript and should be a better evaluation of the student's performance while at HMS.

#### *Official Policy Statement on Confidentiality of Students' Records:*

There are two types of records kept in the registrar's office: (1) an academic record which contains the transcript of grades; any official comments concerning performance submitted with the grades; and the internship letter and (2) a "*folder*" which contains miscellaneous official correspondence; other

material such as recommendations written on the student's behalf by members of the administrative staff and faculty; the original application for admission; official actions of the appropriate academic boards of the school; and other correspondence not of a medical or health nature. Medical and health records are not kept in the registrar's office. An official Medical School transcript contains only grades. The Joint Administrative Board-Student-Faculty Committee recommends:

- (A) *Only the dean of the Medical School, the student affairs office, the registrar's office, the preclinical promotions board, the preclinical advisory board, the appeals board, the clinical review board, the examinations committee, the curriculum advisor, the internship advisor and the student should have access to the academic record as kept in the registrar's office.*
- (B) *Individual faculty members who are asked by a student to write letters of recommendation on the student's behalf should not have access to the academic record unless the student, in writing, requests the registrar's office to provide that information.*
- (C) *It has been Harvard Medical School's policy not to provide material from the academic record to hospitals as part of the recommendation for the first-year post-graduate training. If an individual student wishes a hospital to receive the transcript and official comments from the academic record, he should notify the registrar's office in writing.*
- (D) *The academic record or folder may only be released to appropriate persons external to the school on written permission of either the student or the graduate.*
- (E) *Only the dean of the Medical School, the student affairs office, and the curriculum and internship advisor should have access to the folder. The appropriate academic boards of the school, if necessary, can request specific additional information from the folder to aid in their deliberations.*
- (F) *The material contained in the folder shall be conveyed to the student at*



*the discretion of his advisor to further the education and general welfare of the student.*

With the hope that the quality of teaching at HMS would improve if there were some way to reward good instructors, the Student-Faculty Committee began a Faculty Evaluation Project several years ago. The plan is for the two Student-Faculty Committee representatives from each class to distribute an evaluation form at the end of each course for students to evaluate their lecturers and section leaders. These

are then collected and summarized.

The final evaluations are sent to each course chairman to help him determine how well the students received the course instructors and to help plan the teaching assignments for the following year. We also encourage the course chairman to convey the results to the individual instructors. This is the only form of constructive feedback that an instructor normally receives.

Finally, at the end of each year, based on the evaluations, the three best teachers in each course are selected.

They are notified, and letters are sent to their department chairmen and the various promotions boards. Hopefully, this will put the spotlight on the very best lecturers and section leaders.

The Class of 1976 was the first to carry out this project completely. As a result of their work and the cooperation of the various course chairmen, the teaching in some of the courses was much improved for the Class of 1977. We hope that future classes will continue to carry on this project, as the results benefit both instructors and students.

## The Student Liasion Committee

by Leslie M. Greenberg '77

*Leslie M. Greenberg '77, having finished the first year of Harvard Medical School, is sensitive to the problems of coping while an undergraduate. To make the transition to medical school easier for incoming students, he has been the main force behind the new Student Liaison Committee. He would like to hear from alumni interested in working with this new committee.*

Harvard Medical School is a large, complex institution. An applicant is greeted only by a foreboding gray quadrangle with the words "Harvard Medical School" carved in marble above Building A. If the applicant has the misfortune to arrive on a gray, rainy day, he or she may well find the Quadrangle completely deserted, as I did. In the past, students have arrived for their interviews only to learn that Massachusetts General Hospital is on the other side of town and that they have five minutes to get there. In their haste not to be late, their impression of HMS is a quick view of the Quad.

Harvard Medical School is much more than a gray Quad or a busy corridor in a hospital. HMS is people, experiences, and attitudes. In the past year many people have been trying to increase the information flow about and within HMS.

The Student Liaison Committee is a group of interested students who have been working to make life within the Medical School a more valuable experience by trying to increase information flow and to provide the chance for interactions among students, applicants, and alumni. We believe that

each group should have the opportunity to benefit from the experiences of their predecessors instead of having to suffer the same problems in a vacuum.

The Student Liaison Committee (SLC) is in the process of setting up a program whereby applicants coming to the school will have the opportunity to speak to current students and to see more of the school. We feel that, in this way, the applicant will have more information on which to base a decision.

When a student arrives at HMS to begin the first year, he or she is faced with a whole new environment. If the student can turn to someone and ask questions, it makes life a bit easier. The SLC is setting up a program in which each first-year student has an upperclass "advisor," along the lines of a big brother-big sister program. This upperclass advisor can help the first-year student cope with the problems of adjusting to a new lifestyle and environment. The problem may be merely finding a good place to eat on weekends or buying the best book to use for a certain course. If the student has problems that the advisor is unequipped to handle, the advisor still has

more experience with the HMS structure and can refer the first-year student to the proper person or office. Second, third, and fourth-year students will serve as advisors, show applicants around, and talk to them. First-year students are invited to help show applicants around and to speak to them after they have had a few months to get oriented themselves.

Students at HMS are exposed predominantly to academic physicians. The SLC feels that, while this is very valuable, students should have the opportunity to meet and spend time with physicians in other types of practices to provide alternative role-models. The SLC, in cooperation with the HMS alumni office, is organizing a program in which students can spend a day or a weekend with an HMS alumnus/alumna in private practice. Students in all four classes are invited to participate in the alumni program.

The SLC is presently funded by the student affairs office and is a student organized, student run, voluntary group. No information regarding applicants who come for interviews and are shown around by students will be transmitted to the admissions committee. This new program is strictly for the benefit of the applicants. The Student Liaison Committee is endorsed by the HMS Admissions Committee and the Student-Faculty Committee.

# Portrait of an HMS I

by Paul C. Shellito '77

*Paul C. Shellito '77 writes a frank autobiographical article about his difficulties in adjusting to Harvard Medical School. While none of us can identify with everything Paul Shellito describes, we can identify with certain anxiety-provoking aspects of HMS, whether they be academic, cultural, or social.*

When warm weather returned to Boston in the spring, I began to realize how much I had learned and experienced during my first year at Harvard Medical School. In the spring the physical setting reverted to what it had been when I first arrived. Just as old recordings occasionally heard on the radio can instantaneously transport the memory (or indeed, one's whole being it seems) back to, say, that incredible summer before a senior year in high school, so the sights and smells around HMS, particularly in Vanderbilt Hall, began to mingle in an old way that I had forgotten over the winter. While that flashback lingered, I was capable of perceiving my initial feelings again. But now there is a new light, of course, since I can compare that situation with the present one. It allows me to sympathize with myself a bit and to appreciate which of my thoughts at the time were relatively valid as well as the immense amount of development that a first year student can undergo.

My personal experience began with growing up and going to college in the Midwest. Although I had visited the East Coast a number of times, I had never lived there or seen Boston. In addition, I had almost no previous information about the academic program at HMS, and of course none of the more informal characterizations of the Medical School was able to reach me. My initial thoughts were, in part, composed of the anticipation of living in a possibly exciting city. In spite of the fact that living in a metropolitan area was something that would be quite new to me, I was anxious to experience some of the brighter aspects of Boston, such as the museums, concerts, and historical areas, and for the most part this over-

shadowed any negative feelings that I had about living there. Other preliminary thoughts or apprehensions I had about attending Harvard Medical School involved the academic aspect. It was obvious that for the first time, everyone in my class would be considerably accomplished. Although this certainly would be advantageous, I knew that my academic performance in classes, relative to the rest of the students, would not be as before. This didn't really seem very crucial, however, because as far as I was concerned, admission to Harvard Medical School meant that I was almost assured of receiving a good education and an M.D. In addition, I considered the likelihood of having much less free time than before. My senior year in college and the following summer were great times for me, and I wasn't sure if I would be very happy about having to spend all of my time studying again.

When I arrived in Boston, I had a few days to relax before classes commenced. Since an old college friend was living in Boston then, I had a companion with whom I began to enjoy the finer aspects of the city that I had been anticipating. My summer fantasies coincided very nicely with what I was now experiencing. When I started classes, however, I suddenly found myself among total strangers, a little at a loss for making friends. I had never lived in a dormitory before, and I had never been thrust in with so many new people whom I felt I needed to get to know. Also, I simply had trouble (as perhaps a lot of people did) ending my undergraduate life, and suddenly becoming a member of HMS I. This was particularly true because in college I had what I thought was the best time of

my life, and I had parted with some very close friends there. As a result of this and of the slight inability to make acquaintances, I think perhaps that I lagged a little — not being able to accommodate myself completely to dormitory life or making new friends.

For a while I was a bit lonely, and that, coupled with the new restrictions on my time, meant that at first I didn't have much in particular to look forward to from day to day, which was sometimes slightly depressing. This situation could hardly help changing, as I was eating all my meals and going to most of my classes with the same individuals each day. It seems now that it was more due to the action of a few other warm-hearted people that I began to make some friends. In addition, parties in Vanderbilt Hall as well as some informal get-togethers helped me feel much less alone. One of the great assets of a Harvard Medical School class, I think, is the fact that the admissions process not only brings together those who are competent intellectually but it also, for the most part, selects people who are more than just good students. I enjoyed getting to know my classmates because most seemed to possess a delightful array of outside abilities and interests. Even more pleasant was the discovery that there were students in my class and in those ahead of mine who were willing to put out more than their share of kindness.

Outside of the classroom and the dormitory there were more adjustments and discoveries. As I suggested above, I wasn't certain if life in a city like Boston would appeal to me in the long run. That suspicion is probably still with me. Boston was most likely more of a culture shock to me than to most of HMS I because of my previous experiences and background. I came biased with an affection for the long open spaces, and I never before had to worry about getting gasoline or getting mugged. These facts, coupled with the pollution and the confinement in such a city, became pretty meaningful to me. For a while, Boston's advantages no longer so effectively outweighed the less agreeable aspects. However, I had to look upon the matter as a desirable learning experience, since that was part of the reason I had come to HMS. I never regretted coming to Boston, but it was a change. In spite of the task of ac-



commodating myself to living in Boston, I wasn't disappointed in the things that I had looked forward to before I arrived. People in my class who weren't so new to the area helped introduce me to a lot of good times in Cambridge and elsewhere. The museums were everything that I had expected, and I was able to attend the Boston Symphony Orchestra concerts regularly. In fact, it was during one of the BSO's first concerts, early in the fall, that I'm sure I felt an initial contentment about being in Boston. What I had to learn in discovering the city was that it was more than merely the crime, the garbage, and the extra hassles — that the beauty was of a kind different from what I had been accustomed to. The same thing was true, I found, of the East Coast in general. I had the opportunity to visit New Hampshire a number of times only to discover that, even there, the density of people was more than I expected.

The classroom experience itself at Harvard Medical School varied a great deal during the first year. It was certainly one of my chief concerns and, at times, disappointments. Often, I wasn't happy with much of the teaching that I received in the first semester. I was aware that the institution had a lot of other important things with which to occupy itself besides the instruction of first-year students, but the level of teaching and organization so often evident during those months made me feel as if beginning medical students were rather incidental, as far as the rest of the school was concerned. There were times when lectures seemed astonishingly poor, especially in comparison to what I had expected. The condition did not arise from any lack of knowledge or integrity of our instructors, but it was instead probably because of a lack of organization, appreciation of the students' level of knowledge, and actual individual teaching skills. There were, to be sure, very notable exceptions to this, but my disappointment arose from the mistaken expectation that unnecessarily confusing and frustrating classes would be rare occurrences.

Another disturbing situation was the quality of student-faculty relations during that first semester. In the fall, the majority of our class expressed its dislike for the four-tier grading system then in effect. Unfortunately, although not completely unexpectedly, this evoked

animosity from many faculty members (as it had among numerous students). For a while the situation caused some friction, and although the *issue* seemed valid to me, I was discouraged somewhat by the way in which students and faculty were reacting to each other and by surprising threats from important faculty members. I felt that perhaps in general we should be working more *with* one another — even enjoying one another. Luckily, the academic situation began to improve during the following semester. This also may have been partially because of the fact that I was simply becoming accustomed to Harvard Medical School. But I am sure that our classes and our teaching began to change for the better as well, and I felt that there was in general more organization and more appreciation by the instructors of the students. I still affirm my initial complaints about many of the first semester courses. Perhaps I'll always recall that lengthy finals period in December as the culmination of a learning period that was sometimes consider-

ably less than pleasant. In addition, although the warnings of upperclassmen and some faculty members implied that after the first semester classes would really begin to get tough, I definitely felt more at ease with the courses and satisfied with the instruction, as well as with what I was learning, during the second half of the year.

I think that perhaps all these impressions will dart instantly and vividly through my mind whenever I catch those familiar sights and smells around the Quadrangle, long after I'm gone from room 347, Vanderbilt Hall. They will always remind me of the unexpected, abundant, but often subtle experiences that a first-year student can have at Harvard Medical School. In spite of several drawbacks, I have, without a doubt, been happy that I came here. Much of the instruction *did* improve during the year, as relations with classmates as well as East Coast living became more and more gratifying.

## Marriage to a Female HMSer

by Bradley E. Alger

*I thought that Perspectives should acknowledge the increasing number of medical student husbands, who will eventually succeed in destroying old-fashioned stereotypes. Bradley E. Alger, a graduate student in psychology at Harvard, is married to Lindsay Staubus Alger, a third-year medical student.*

Having a wife who is a medical student is a situation commonly fraught with difficulties, or so I am assured from time to time. And from that point of view, I may not be well qualified to write this essay, being in the atypical position, thus far, of taking more pleasure than pain in my wife's vocation. "Thus far" because she has only finished her second year, and, again I am assured, the third year is the worst.

Of the distinctive concerns of non-medical husbands with medical wives, the first that comes to mind (assuming, naturally, that you have already assimilated the idea that no would-be doctor spends all her time frantically cleaning house, preparing meals, or in general

hovering about, attentive to her husband's every beck) has to do with the Harvard Medical School surround. The environment in which HMS is situated is not uniformly reassuring to one accustomed to having his wife work late at school, even to one used to seeing her return home safely. The city is the source of all the wonderful clinical experience for which Harvard is noted and, partly therefore, is no place in which women should walk at night.

Because Lindsay is going to be a doctor, we have been forced to consider, with alarming seriousness at times, questions concerned with having children. It is alarming in the sense that, despite the fact that neither of us wants

children for several years, we do plan to have them, and decisions in the relatively near future will have to be made with them in mind. "When" is a major topic. It is interesting to learn that various statistics conspire to make a woman's bearing children before age 30 seem desirable. But "when" is also constrained by a whole slew of factors, many of which are related to the structure of medical education and practice in this country. More opportunities for part-time programs and types of group practice would be helpful in allowing doctors to take part in the rearing of their offspring. Such programs probably would require more medical schools and more doctors; the necessary changes will not be easy. In any case, two matters even more fundamental than AMA politics are involved. The first is the particular one of which specialty to pursue, some being more consonant with having a family than others. The second is the general one of what style of physician to be, of what sorts of goals to strive for. That is, my wife, originally a normal, competitive, pre-med type person, occasionally has a desire to try to scramble up the heap to become Chief Doctor of the Western Hemisphere, or a similar exalted rank. She also wants to have a hand in raising children and in fact, other things being equal, would like to follow a path that would allow her to maintain an interesting, challenging career and to have a family. It is not clear that this is always possible. Yet it seems to be true that the problem is of immediate interest since grades, locations of clerkships, and research are all important for the ambitious.

Returning to the homier issues of day-to-day living, there is the unique schedule of medical school courses. Because I am also a student, my time off is as limited as my wife's. What is difficult is that we are almost never off at the same time. If I have just finished a set of exams, it is certain that she is just beginning one. This inability to enjoy our brief vacations together was a prime annoyance during the first year.

Nights away from home are supposed to make some clerkships especially desolate periods, and there is no reason to doubt this will be so. It is undeniable that at times the tensions of medical school have interfered with our sex life. Since puberty, many things have interfered with my sex life. There-

fore, surviving these interruptions should be possible, but it is not a time to which one looks forward eagerly.

Nights away from home, incidentally, will be made doubly desolate for some by the thought of the plethora of male students, interns, etc., all staying the night where married female students are also staying the night. Indeed, medical school in general is not constituted to give peace of mind to a husband with any leanings toward jealousy. There is a three-to-one male-female ratio, and that means every woman receives her share of attention. Presumably the first-year marriage boom relieves some of the pressures, but it is always possible to hear stories.

In the real world a disparate male-female ratio frequently has implications regarding discrimination based on sex. And, while for the most part the Harvard medical community doesn't do too bad a job, still, for the record, I would like to take this opportunity to wonder whether it is true that for certain clerkships there are no adequate separate sleeping quarters for women and that for others the dressing facilities are of inferior quality. And, of course, if so, why?

A final nuance of married life with a woman medical student evinces itself at parties. I am proud that Lindsay is going to become a doctor and furthermore have no trouble admitting that she goes to Harvard. As a result, there is a particular awkwardness when we meet the wives of some of my friends, those whose occupation is unglamorous and who feel the worse for an implicit comparison. It is a peculiarly ambiguous position for me to be in because courtesy to them seems to demand de-emphasizing the pleasure I take in my wife's achievements, while, at the same time, it is not fair to Lindsay to pretend for appearance's sake that she is just another wife with just another job.

In fact, life in general does not live like just another life. It is busy, interesting, and enjoyable. The hardships are offset by benefits, God is in His Heaven, and all is as right as can reasonably be expected at this point. I could not be happy with someone who did not have her own serious interests, some job of her own to carry out which preferably has nothing to do with me. I consider myself lucky to have found someone to love who is like that.

## A View from the Couch

by Samuel Bojar, M.D.

*Samuel Bojar, M.D., psychiatrist to the Medical Area Health Service, has helped thousands of students cope with the demands of medical school. He is an exceedingly popular physician who always eats lunch in Vanderbilt Hall and who will always make time to see the student who has suddenly plummeted into a crisis. Everyone I know who has received counseling from Dr. Bojar has been grateful.*

Before coming to Medical School you undoubtedly heard all sorts of comments about how hard the work would be, the long hours you would spend studying, the dangerous exposure to disease, and similar truths, halftruths, and myths. Whatever you may have heard, however, you may rest assured that by virtue of being a medical student you are not any more susceptible to disease, nor are you granted any particular immunities. Should you, however, develop any medical problems, be they physical or emotional, the Medical Area Health Service stands ready to help you. This prepaid plan provides com-

prehensive diagnostic, therapeutic, and preventive medical care.

The Medical Area Health Service is a unit of the Harvard University Health Services. The service is staffed by male and female physicians who offer medical and gynecological care, a psychiatrist, a technician-medical assistant, and secretaries who are responsive to your requests for medical attention. Surgeons and other specialists are available for consultation. Dr. James J. Feeney is the Director of the Medical Area Health Services, and Dr. Samuel Bojar is the psychiatrist.



The Health Service has a policy of wanting to know the student population, and each member on entering HMS and Harvard School of Dental Medicine classes is given an appointment for a physical examination and a personal interview. These give you the opportunity to get to know the doctors to whom you can turn for medical and emotional help, personal counseling, and advice.

The members of the MAHS are teachers and advisors as well as clinicians, and their philosophy is to offer the best possible medical care as a teaching as well as a therapeutic medium. Along this same theme is their feeling about stringently observed doctor-patient confidentiality. No information about your consultations is released to others without your written permission.

At some time during your medical school career, you may find yourself seeking advice, counseling, or even therapy for a personal question or emotional problem. Medical education has gone through numerous phases of change since the days of Hippocrates, but whatever guise it has assumed, it has always involved an intimacy of subject matter and interpersonal relationship that entails emotional stress. You will not be the first medical student to have felt the emotional impact, nor will you be the last, so you need not feel it to be a reflection on your capability or stability.

As you enter Medical School, you come into what for you may be a new, exciting, perhaps strange and unknown world — the world of medicine. One can imagine a wide scope of anxieties that a new medical student may experience. Your classmates will be coming from many different colleges, and many of you may be the sole representatives of your respective colleges. You may be severing old ties, giving up a former group identification for an as yet unformed one, and though many new friendships will be coming your way, the anxiety and depression of the separation may persist.

You may come with preconceived fantasies about Harvard and about how difficult it might be to succeed at HMS. In many undergraduate colleges, competition for grades and class rank is quite intense. At HMS, instead of letter

or numerical grades there are only three tiers of evaluation — Excellent, Satisfactory, and Unsatisfactory. Hopefully, this deemphasis on grades will foster learning for the sake of learning. Not knowing where you stand *vis à vis* your classmates may cause you some concern. The premed competitiveness may persist but it does not contribute to effective learning, nor does it foster good interpersonal relationships with your new classmates. Grades or no grades, be prepared to meet with a seemingly endless succession of tests as each department seeks to determine how well it has taught and how much you have learned. Anxiety will accompany your preparation, and you may approach each test with apprehension — but is this any different from what you experienced in college?

During your preclinical years you will be thrown together with your classmates much more than you were in undergraduate college, with its individually tailored program of courses. An intimacy is fostered that some find to be pleasant and comfortable but that others feel as a strain on their ability to cope. The increase in the number of women in the entering classes no longer permits their image as "the nicest guys in the class." Emotional reorientation is necessary for both women and men to see themselves and each other as social beings as well as medical students, to have both social and professional relationships. And, of course, in these roles, more mature demands are faced than had been met before.

"Second-year medical students' syndrome" is traditional in repute but apochryphal in reality. You are supposed to develop every disease you study, but you need not sleep anxiously on this score. The usual experience has been to be worried and to wonder about some symptoms but then to dismiss them as irrelevant. Only an occasional student takes the syndrome seriously.

There are other anxieties that await you during your medical school career after you have weathered the high winds of course lectures and the squalls of the frequent tests. When you go on to Examination of the Patient/Introduction to the Clinic, you will have your first personal exposure to the role of the physician. Coupled with the eager anticipa-

tion is the uneasiness about how to approach a patient — what does one say? What does one do? How will one be received by the patient? As a future physician? Or as a student who does not know what it's all about? This experience introduces you to the emotional and mental as well as physical pressures of the clinical years which are themselves punctuated by Parts I & II of the National Board Exams.

A stressful period unique to the fourth year class involves hospital visiting, internship applications, and finally Internship Matching Day. Matching Day is greeted with cheers or tears, after which the realization of the hard-worked-for ambition to become an M.D. rapidly approaches. It is usually tempered by the doubts that accompany a new adventure — this time that of internship, of actually bearing the doctor's responsibility for the health and perhaps the life of the patient.

Married students are faced with still other problems. The married student who is supported by and depends on the spouse has inevitable conflicts — as does the spouse, who may react to the perception of being married to the student, who in turn seems to be married to the books. During the clinical years the spouse may find it difficult to cope with the long hours and the every other or every third night on duty of the major clinical clerkships.

There are numerous other concerns that you may have about Harvard Medical School and its effect on your social life. You may feel that it restricts the development of new outside friendships and perhaps that it creates psychological distance between you and your old acquaintances. Until you discover how best to apportion your time, you may complain that study demands so much of your time that you feel narrowed in your cultural, athletic, and social interests.

And, of course, there are any number of personal questions that are not unique to the medical student but for which you may seek answers: family, social, sexual, career choice, etc. All the MAHS staff physicians are ready to help with professional advice.



Since 1812, The New England Journal of Medicine has played its role in medical circles—reporting the progress of medicine to physicians and medical students throughout the world.



# The New England Journal of Medicine

10 SHATTUCK STREET, BOSTON, MASSACHUSETTS 02115



**after taking a  
potent analgesic  
360 times  
in 3 months...**



## how big a dose will now bring relief if it is a narcotic?

"Tolerance is an ever-present hazard to continued use of narcotics.... The very first dose diminishes the effects of subsequent doses."<sup>1</sup> And, as increasing amounts of narcotics are required to control pain, distressing adverse effects—lethargy, hypotension, constipation, etc.—can needlessly debilitate the patient.

1. Sadove, M. S.: A look at narcotic and non-narcotic analgesics, *Postgrad. Med.* 49:102, June 1971.

## how big a dose will now bring relief if it is Talwin®?

Chances are, the same 50 mg. Talwin Tablet you prescribe originally will continue to provide good pain relief. Talwin can be compared to codeine in analgesic efficacy: one 50 mg. tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. However, patients receiving Talwin Tablets for prolonged periods face fewer of the consequences you've come to expect with narcotics. There should be fewer "adverse effects" on her way of life.

**Tolerance rare:** Tolerance to the analgesic effect of Talwin Tablets is rare.

**Dependence rare:** During three years of wide clinical use, there have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

*In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.\**

**Generally well tolerated by most patients\*:** Infrequently causes decrease in blood pressure or tachycardia; rarely causes respiratory depression or urinary retention; seldom causes diarrhea or constipation. Acute, transient CNS effects, described in product information, have occurred in rare instances following the use of Talwin Tablets. If dizziness, lightheadedness, nausea, or vomiting is encountered, these effects may decrease or disappear after the first few doses.

\*See important product information for adverse reactions, patient selection, prescribing and precautionary recommendations.

## in chronic pain of moderate to severe intensity

# Talwin®

50 mg.  
Tablets

brand of  
**pentazocine**  
(as hydrochloride)

Talwin® Tablets brand of pentazocine (as hydrochloride)

Analgesic for Oral Use—

**Indication:** For the relief of moderate to severe pain.

**Contraindication:** Talwin should not be administered to patients who are hypersensitive to it.

**Warnings:** *Drug Dependence.* There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

*In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.*

**Head Injury and Increased Intracranial Pressure.** The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

**Usage in Pregnancy.** Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

**Acute CNS Manifestations.** Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is re-instituted it should be done with caution since the acute CNS manifestations may recur.

**Usage in Children.** Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Ambulatory Patients.** Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

**Precautions:** *Certain Respiratory Conditions.* Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

**Impaired Renal or Hepatic Function.** Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

**Myocardial Infarction.** As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

**Biliary Surgery.** Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

**Patients Receiving Narcotics.** Talwin is a mild narcotic antagonist. Some patients previously given narcotics, including methadone for the daily treatment of narcotic dependence, have experienced withdrawal symptoms after receiving Talwin.

**CNS Effect.** Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

**Adverse Reactions:** Reactions reported after oral administration of Talwin include *gastrointestinal:* nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. *CNS effects:* dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see *Acute CNS Manifestations* under **WARNINGS**); and rarely tremor, irritability, excitement, tinnitus. *Autonomic:* sweating; infrequently flushing; and rarely chills. *Allergic:* infrequently rash; and rarely urticaria, edema of the face. *Cardiovascular:* infrequently decrease in blood pressure, tachycardia. *Hematologic:* rarely depression of white blood cells (especially granulocytes), usually reversible and usually associated with diseases or other drugs which are known to cause such changes, moderate transient eosinophilia. *Other:* rarely respiratory depression, urinary retention, toxic epidermal necrolysis.

**Dosage and Administration:** *Adults.* The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

**Children Under 12 Years of Age.** Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

**Duration of Therapy.** Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see **WARNINGS**). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

**Overdosage:** *Manifestations.* Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

**Treatment.** Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are not effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist.

Talwin is not subject to narcotic controls.

**How Supplied:** Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.



